Medicaid Advisory Committee Meeting Notes 2005

January 19, 2005

February 24, 2005

April 20, 2005

May 9, 2005

July 19, 2005

September 8, 2005

November 3, 2005

December 1, 2005

Medicaid Advisory Committee
November 3, 2005
Room 257, State Capitol

Present: Michael Garland, Tina Kotek, Yves Lefranc, MD, Carole Romm, Jim Russell, Carmen, Urbina

Absent: Bruce Bliatout, Elizabeth Byers, Donna Crawford, Kelley Kaiser, Dick Stenson, Rick Wopat, MD

OHPR: Bob DiPrete, Kelley Cullison

OMAP: Lynn Read, Susan Chuculate

Opening Remarks

Tina Kotek shared a recent article that Colorado voters overturned their spending cap limitation. She believes it was a positive step for one state that went down the wrong path and corrected themselves. Tina noted that Oregon may be looking at a spending cap ballot measure next fall and expressed her hope that Oregon can learn from Colorado's experience: more children lost coverage in Colorado during the period of the spending cap.

Introduction of New Members

Bob DiPrete introduced Mike Volpe who will soon be appointed to the Medicaid Advisory Committee. Mike has an extensive background with the Oregon Health Plan (OHP) which includes serving on other advisory bodies.

Introductions were made by the Committee.

Bob DiPrete thanked Michael Garland, who will be leaving the Committee but remaining as a resource, for his commitment over the past years to the Medicaid Advisory Committee.

Approval of Minutes

Tina Kotek asked the Committee for a motion to approve minutes of the public hearing on September 8. The minutes were approved as written.

Update on Budget Cuts

Lynn Read explained that the Department of Human Services (DHS) was moving forward with three waiver amendment requests that were submitted to the Centers for Medicare and Medicaid Services (CMS) but have not been approved as yet.

The first waiver amendment relates to changes in the premium structure in terms of who owes OHP Standard premiums and how long they have to pay them in terms of grace periods. At this point CMS has taken no action. They don't have an issue with the policy per se but have a more fundamental issue with the fact that Oregon may be the only state that currently has approval to claim federal match on premium collections. CMS may be revisiting that issue.

If Oregon receives CMS approval by the 18th of the month, they would be able to implement in 60 days. Until then, the current policy will remain in place.

The second waiver amendment request was a request for benefits reductions. DHS' analysis indicated that the agency was restricted in its ability to substitute alternative actions for those that had been identified during the budget development process, and so DHS submitted the four items presented to the Committee at the last meeting:

- Elimination of the routine vision benefit for OHP Plus adults with the exception of pregnant women
- Limitations on over-the-counter drugs within the realm of the discussion held at the last meeting with the principles in place that was discussed.
- Limitation on OHP Plus dental of about $1.7 million General Fund. DHS worked that through with stakeholders, primarily the Dental Care Organizations, in terms of finding a package that would work best.
- The 18-day Hospital Limit for DRG (Diagnosis Related Group) hospitals remains in the package. The limit doesn't apply to managed care, Type A & B hospitals, or Medicare dual eligibles. This item is expected to require a lot of discussion with CMS in terms of equity in

terms and how it impacts individual groups of clients, different geographical areas and different delivery systems.

Questions related to hospital day reductions, what savings were anticipated, what percent did that represent of the total DRG hospital budget? A handout was given to members indicating 1.4% of the DRG budget which is $243 million for the biennium.

Another question related to hospital days requested information on who would be impacted, what geographic areas would be impacted, and what types of hospitalizations would be impacted with the hospital day limit. The handout includes only one of those questions answered.

Two missing pieces from the packet handed to Committee members were addressed:

1) Of those hospitalizations that occurred after the 18th day, how did they spread out among the various eligibility groups? The Aid to the Blind/Aid to the Disabled categories accounted for approximately 84%. Another 8% was in the General Assistance category which has since been eliminated, and most of those clients have moved over into the Aid to the Disabled programs.

The other missing piece of information was the distribution of hospitalizations that were after the 18th day and how they were distributed among the various hospitals. The database included both Type A&B and DRG hospitals so some of that information is included.

Carole Romm asked Lynn Read what data might not actually fall under this rule because the clients could in be managed care or dual eligibles.

Lynn Read responded that the database had excluded the dual eligibles and did not include managed care; only the fee-for-service experience is reflected. The percentages will change a bit because the data does include some Type A and B hospitals, and the action as proposed, wouldn't apply to Type A and B hospitals.

Lynn Read indicated that the waiver amendment was submitted to CMS on October 18th. It's too early to foresee approval or be too engaged in dialogue

with CMS. The savings were priced assuming OMAP will implement July 1, 2006.

Update on Reallocation

The third waiver amendment that OMAP submitted to CMS was related to an update on reallocation. The Legislature took the $4 million of General Fund appropriated to the Insurance Pool Governing Board (IPGB) budget for the Family Health Insurance Assistance Program (FHIAP) in order to meet the federal requirement related to the amount of state money Oregon is supposed to spend on that program over five years. The money was put in a Special Purpose Appropriation with the Legislative Emergency Board and DHS was asked to seek flexibility from the Centers for Medicare and Medicaid Services (CMS) in order to give the Legislative Emergency Board some choices on how that money could be spent and still count towards the required Maintenance of Effort requirement.

OMAP submitted part of the Committee's recommendation in a request to CMS on September 14th requesting flexibility to spend the money on OHP Standard; continuous eligibility in the CHIP program, moving from the six-month certification to 12 months; eliminating the assets test, currently at $10,000 for the CHIP program; and taking CHIP from the current 185% of federal poverty to 200%. OMAP did not submit the Committee's recommendation to eliminate the six-month uninsurance component. A fifth choice would be spending the money on the Family Health Insurance Assistance Program.

OMAP reported to the October 27the Legislative Emergency Board on the status of the negotiations with CMS. In that letter the Executive Branch actually recommended the policy choice that the Legislative Emergency Board should focus on extending eligibility from 6 months to 12 months from among the alternatives noted. The Legislative Emergency Board allocated $2.9 million of the $4 million to the FHIAP program, with $1.41 million remaining in the Special Purpose Appropriation fund.

DHS will propose the recommendation by the Executive Branch of 12-months continuous eligibility for the Children's Health Insurance Program (CHIP) from CMS. DHS also will push for approval from CMS to take FHIAP and CHIP kids from 185% to 200% of the poverty level. During interactions with CMS that was the option that seemed to resonate the most.

If CMS approves both, DHS would notify CMS after the January Legislative Emergency Board meeting of planned implementation dates. If there is no answer from CMS or the Legislative Emergency Board takes no action in January, the money would automatically go back to the FHIAP program at the end of June.

Tina Kotek asked Committee members for questions based on the three waiver amendment requests.

Premiums

Tina Kotek asked Lynn Read if she could reiterate the issue around the federal match in premiums and why that is an issue now?

Lynn Read responded that back in 1995 when DHS implemented the OHP expansion for adults, they requested specifically for authority to take that premium revenue, use it as if it were state funds and draw down federal match so that they could buy more enrollees with that money. Since then CMS has not approved that type of request for any states, and they had lost track of having done so for Oregon. This has really created a policy issue for CMS on whether or not they are going to allow DHS to continue this practice, whether or not it has to stop now, or they might wait until the renewal of the waiver in 2007. The various options are of concern.

Oregon's statutory framework requires Oregon to continue to charge premiums even if CMS determines that federal match will be denied. Lynn Read explained the federal matching process and the premium collection process to Committee members.

Carole Romm asked if the premiums were substituting for dollars put into the program and if the agency was losing match on that too.

Lynn Read responded that the overall expenditure is the same. It still costs the same amount of money to serve the OHP Standard clients. The question is really whether or not the premium paid by the client can draw down federal match.

Carole Romm asked if there wasn't premium sharing by clients, would the state bear that extra cost? Could that extra cost be matched?

Lynn Read responded yes if there was General Fund revenue to replace the lost premium revenue from clients.

Tina Kotek asked Lynn Read to provide the Committee with a cost analysis if there needs to be a policy change. It would be nice to see those numbers written out in such a way to see why it's not cost effective any longer to collect premiums if we don't have match. That would become a policy discussion about the advisability of maintaining premium sharing by clients if there is no federal match available.

Lynn Read explained that it's DHS' hope that they will have some definitive answers from CMS in time to include in developing legislative concepts and budget packages to move forward for the next legislative session.

Carmen Urbina asked Lynn Read when she expected a decision from CMS.

Lynn Read indicated she had no idea because it's unclear that DHS would want to push it. Yet, on the other hand, DHS would need something in order to figure out what needs to be done in the next legislative session if CMS goes in that direction.

Carole Romm inquired if CMS rejected and turned back the clock on matching the premiums, and it became really clear that this was costing more money than it was producing, and also impacting the citizens of the state who are unable to access Medicaid as a result, whether there would there be any opportunity to go to the Legislative Emergency Board to ask them to change this premium rule?

Lynn Read believes that it would require a statutory change because SB 782, which is now in statute, says that the OHP charges premiums, except for those under 10% of the federal poverty level.

Michael Garland suggested it might be helpful to know what the magnitude of the budget is for premium collections.

Lynn Read responded she has asked budget staff to provide that. Lynn will provide an update on that at the next Committee meeting.

Action items:
Tina Kotek asked for Lynn to keep the Committee informed of where CMS is on this request.

Lynn Read will provide an update at the next Committee meeting.

Benefit Reductions

Tina Kotek asked the Committee if they had any questions regarding the waiver amendment request submitted to CMS related to Benefit Reductions: vision, OHP Plus dental, over-the counter drugs and the 18-day cap on hospital stays.

Jim Russell asked Lynn Read to clarify what she said when she reconsidered the options for changing the proposed budget benefit reductions. The particular reductions proposed were in the development of the Governor's Budget and that the Agency couldn't propose other choices.

Lynn Read answered that was correct based upon interaction with the Department of Justice.

Jim Russell asked what was the role of the public hearing in September. If the Committee had the Department of Justice (DOJ) opinion prior to the hearing, they wouldn't have needed to hear that issue.

Lynn Read responded that it is correct that OMAP didn't have the opinion prior to the hearing. Lynn believes it still had value in identifying where some of the issues are, and those will surface in the course of discussions and also in creating a record of the concerns.

Tina Kotek asked who requested analysis from the Department of Justice (DOJ)? Was it seeking legislative intent or interpretation of the actual legislation?

Lynn Read explained although she was at not liberty to actually share a DOJ opinion, the basic issue was not the legislation itself because the legislation in statute doesn't get to that level of detail.

Carole Romm asked if the Agency had further conversations with the hospitals regarding the reductions.

Lynn Read responded that those discussions have occurred. Some of the ideas that surfaced and the discussions are broader than just the benefit reductions. Some of the ideas that have surfaced:

- Restructuring the way outlier payments are made to DRG hospitals.
- Slightly increasing hospital provider tax
- Lowering the DRG base for payments made to all hospitals to more equitably spread the cut
- Spreading the reduction more broadly to include managed care plans as well as fee for service.

Lynn reported that there was not broad-based support for any of those options. In the meantime, DHS received the DOJ opinion, and submitted the request. Lynn Read expects considerable dialogue with CMS on the issue.

Kevin Earls stated hospitals did have another meeting with DHS. The Hospital Association submitted a list of eight questions/recommendations. The overarching issue is the equity discussion around the fact that this budget cut targets specific communities and specific types of eligibility categories in a pretty significant way. The recommendation that the Association had was to try to find a way to blend the cut across all lines of service and eligibility categories so that it was uniformly applied which was more in keeping with the architecture of the Oregon Health Plan. The Hospital Association believes there are legal issues in providing different benefits to different groups in the Medicaid program, simply by virtue in one instance of where they live in the state and had asked DHS to initiate a dialogue with CMS in advance of taking that action. The Hospital Association's other recommendations were an attempt to try and make the cuts in a way that was more in keeping with the original architecture of the Health Plan so it didn't target age/blind/disabled people, or just those areas that didn't have managed care or just a certain type of reimbursement structure. Kevin will provide those recommendations to the Committee.

Action item:
Kevin Earls will provide the list of the eight Hospital Association recommendations to the Committee.

Carole Romm asked if any kind of consensus was arrived at.

Kevin Earls replied that among hospitals there was a consensus on a strategy that blended these cuts. One of the cuts that the Committee hasn't talked about specifically is the graduate medical education that targets just the teaching institutions. The Hospital Association is concerned about that. The Association felt strongly that the cuts be made in a way to apply them more broadly and uniformly and not target specific institutions or regions of the state or eligibility categories, or managed care vs. fee for service.

Bruce Bishop asked if the 1.4% cut is taking the one-year reduction and applying that against a two-year budget? It would be then a 2.8% cut.

Lynn Read responded she hoped that was not be the case but she didn't know what the underlying numbers were, but would find out.

Bruce Bishop added that the numbers look misleading. He would appreciate follow-up.

Action item:
Lynn Read will provide a follow-up on the 1.4% cut.

Bruce Bishop noted that in August, the Hospital Association asked DHS for specific answers about what the impact of the 18-day cut would be on populations for hospitals. The agency has apparently still been unable to furnish that information which makes it difficult to have a discussion about alternatives without a baseline.

Lynn Read said she would double check the math that went into the calculations of 1.4%. It was her belief that the data on hospital days was sent electronically to the members of the hospital workgroup but she would verify and that and also have it sent electronically to the Committee.

Mike Volpe inquired if clients who are enrolled in the Primary Care Case Management (PCCM) program, and not in a health plan, are considered fee for service?

Lynn Read responded they were.

Tina Kotek requested that Lynn Read provide a compilation of all the budget reductions and their impacts for this current biennium because she recalls the

Committee had the set that was responsive to CMS approval and then OMAP had the other ones like graduate medical education. She hasn't seen one document that includes the non-CMS required approval budget reductions. Lynn Read mentioned the document had been forwarded to the Committee but it just identified dollar amounts.

Action item:
Lynn Read would check with DHS budget staff to see if impacts were identified on the budget reductions.

Tina Kotek asked if that document also has the details of the dental change. There was confusion around what was being proposed.

Lynn Read explained just dollar amounts were listed. The details were being worked out with dental care organizations.

Action item:
Lynn Read will check to see if anything has been written up on the details of the proposed dental changes and share with the Committee.

Tina Kotek requested that any document DHS sends to Centers for Medicare and Medicaid Services (CMS) also be copied to the Medicaid Advisory Committee.

Jim Russell indicated the 18-day hospital limit will have a significant impact on mental health hospitalizations. Many clients are hospitalized for mental health diagnoses for a lot longer than 18 days, in part, because there is no place else to put them.

Carmen Urbina requested a summary of the populations impacted, depending on the decision from CMS**.** She wants the data to be humanized so she can understand numbers as well as human beings.

Carole Romm reflected on the process and said it seems to be a really bad policy decision the Committee was asked to comment on after the fact. This policy was developed, the Committee heard about it in the hearing, and the 'train is down the track' by the time the MAC has commented. She asked how the Committee could provide advice earlier in the process? When faced with cuts like that, could the Committee be a sounding board before a policy

decision is made rather than being asked to comment on a policy decision that really doesn't make sense.

Tina Kotek believes one of the things that would really help is input from the Committee on the development of the Governor's Budget because ultimately that becomes a template of which DOJ was making their analysis.

Lynn Read said that OMAP has routinely brought in a number of different stakeholders in different settings in pieces of the development of the budget. Lynn explained the budget development process from the Agency Request Budget through the legislative process to Committee members.

Michael Garland noted that this Committee is not a budget analysis committee. It is essentially an advocacy committee for the interests of people who are covered by the Medicaid program and also by the whole of the OHP. He believes in order to be able to have a focus on the human meaning the Committee will have to start early. What is it the Committee really is trying to work on? What is the impact on the people who are Medicaid eligible? This Committee is really charged to see that and keep raising that issue. He thinks it's important to invest immediately in clarifying that vision about the human impacts of proposed change so that the whole budget process can move forward with human impacts clearly identified. He suggested that the MAC be ready to both give input on what information is important and assessments and recommendations based on analysis of this data.

Medicaid Reports and Information.

Tin Kotek mentioned that OMAP produces a large number of reports and suggested it would be nice to have some useful regular reports provided to the Committee to help them understand what's going on from a human side as well as the numbers side. The Committee will ask Lynn Read to address what reports are available. The Committee would then come up with a set of things they would like to see on a regular basis if the current reports don't get to what they want.

Carmen Urbina asked the Committee to really think about what is the responsibility of this Committee and how can they communicate with their rural stakeholders in those particular areas so they know what's coming and so they can be prepared.

Lynn Read walked the Committee through the packet of Medicaid Reports and the two links on the DHS website related to the Medical Assistance program:

About Us – Learn more about DHS – Quick Links – The DHS 2005-07 budget development process, the Governor's Recommended Budget, the 2005-07 Ways and Means documents that DHS presented and the Re-estimation of the Governor's Recommended Budget (GRB) are laid out on this link as well as all of the documents that led up to that budget. It provides an opportunity to be informed and submit input and will be pertinent as DHS is moving into the 2007-09 budget development process.

Proposed policy option packages and draft budget reduction option components are included.

The summary of what came out of the latest legislative session will be included on the website soon.

OMAP and stakeholders have the ability to E-Subscribe to the DHS website. Stakeholders can sign up for topics of interest. Every time that topic is updated, subscribers will receive an e-mail notice and a link so that they can go out and look at what the information is about that topic.

Medical Assistance – This link displays all of OMAP's policies related to the program; a number of different kinds of reports, frequently asked questions, forms, and pages related to managed care enrollment and eligibles, and physical medicine benefit package. There is a wide range of information available on the Medical Assistance Program link. Reports are updated on a monthly basis. Lynn Read reminded the Committee that this website is well worth looking into.

Tina Kotek asked Committee members to review this document and asked if it would be more helpful to have a compilation of something OMAP could provide to the Committee that would be more helpful than looking at all these individual reports.

Yves Lefranc had a question regarding access. He has difficulty in referring and placing patients who are enrolled in OHP mental health coverage and sees a real problem in this area. Is there a report that would show access,

places to refer patients, who will take these patients, what are the limitations on numbers and types of patients?

Lynn Read responded that providers have available to them information on whether a given client is enrolled in a mental health organization.

Jim Russell indicated the client's medical ID card includes an access number (an 800 number) for the particular MHO the client is enrolled in. He couldn't guarantee access but suggested Dr. Lefranc start with that number to get a basic evaluation by a covered mental health physician.

Tina Kotek added that it sounds like a disconnect of being enrolled, being covered and having access. She asked whether there is related visit information that could be tracked to determine access to mental health services by OHP enrollees.

Carole Romm suggested the Committee might want to look at utilization data which could be a proxy for access.

Lynn Read explained that DHS has some reports run on a periodic basis that tracks utilization in service categories, by plan, that would start to answer some of that question. It won't put the personal picture together but it would start to give some of that data to see how it varies from one plan to another.

Jim Russell noted that the DHS Office of Mental Health and Addictions website has very detailed reports on that subject.

Tina Kotek encouraged the Committee to think of what would be most helpful for them as an advocacy group so they could have a sense of what's happening. The Committee could create a list of exactly what they would like to see in one report or two on a regular basis and provide that to Lynn to see if that could be generated regularly for the Committee.

Michael Garland suggested that a small subcommittee be created to really spend some time and shape that up.

Action item:
Carmen Urbina and Carol Romm will work with Michael Garland on the data request to identify what kinds of reports will humanize what's going on and will present some ideas at the next Committee meeting.

Carmen Urbina asked if the Committee could create an avenue to communicate with other committees working on the same issues. There needs to be a connectiveness with those groups.

Bob DiPrete recommended having representatives from other advisory committees visit as issues of mutual concern are discussed. He also noted that some members of the Medicaid Advisory Committee are also members of other advisory groups and bring those perspectives to MAC discussions.

Demonstration Waiver Process and Timelines

Lynn Read explained that OMAP will be engaged in renewing the 5-year approval of the OHP Demonstration waiver. By April 30, 2006, OMAP will need to alert CMS of their intent to renew. By October 31, 2006, DHS will have to submit the renewal application. CMS would have to make a decision before the current five-year period ends on October 31, 2007. The problem with that timeframe is it doesn't fit well with the work DHS will be engaged in looking at broader changes in terms of what they want to do with the health plan in the future and moving into the 2007 legislative session. There are all types of groups with ideas about how we can take this program and make it make effective within our reality of today versus the one in 1989 when the enabling legislation was passed. The Executive Branch led by the Governor's office will be involved. There will be a period of going out and soliciting input from various stakeholders in terms of changes that make sense. The Governor will be putting together his initiative of what it is he'd like to accomplish as it relates to health care in the building of his Budget. DHS will need to include those items that impact the Agency into their process which involves the building of the budget and also legislative concepts. By mid April of 2006, DHS has to have their legislative concepts submitted to the Department of Administrative Services and then ultimately they will move over to Legislative Counsel for drafting.

There is also a whole separate parallel in the Legislative branch. The House has set up a committee to look at the Oregon Health Plan, and there are a number of legislators who, on an ad hoc basis, are interested in doing something on health reform as we move toward next session.

Tina Kotek requested that the Committee be provided with a written timeline of those parallel processes.

Benefit Design

Darren Coffman explained the OHP Principles and Policy Objectives document handed out to members. This document was reviewed by the Prioritization Principles workgroup which was created by the Health Services Commission to look at a proposal that former Commission member, Dr. Rick Wopat, presented at their July meeting in terms of a potential re-look at the Prioritized List and what changes might make sense. As the OHP Standard population is shrinking, Dr. Wopat believes that it would make more sense to provide a benefit package that is focused on preventive services and some chronic disease management and be able to provide that type of a benefit package to a broader segment of the population than the richer package that current OHP Standard eligibles receive now. The Prioritization Principles workgroup reviewed what the principles were behind the Oregon Health Plan and how does this new proposal fit within that framework?

Even before the OHP was developed a guiding principle was that all citizens should have universal access to a basic level of care.

This proposal moves in that direction of providing more basic care to a broader segment of the population.

The Health Services Commission (HSC), when looking at basic level of care, asked if it is comprised more of preventive and chronic disease management services as opposed to acute care services? The process must be based on criteria that are publicly debated, reflect a consensus of social values, and considered for the good of society as a whole.

Funding must be explicit and economically sustainable – Darren believes this is coming to the forefront of some of the discussions recently. There must be clear accountability for allocating resources and the consequences of funding decisions.

OHP Design Implementation – The HSC was given a very general path in terms of creating the Prioritized List of Health Services, ranking by priority from most important to least important. The HSC came up with a methodology that did that. They held a number of community meetings, with the help of Michael Garland and Oregon Health Decisions, around the

state to try to help define what social values the benefit package should reflect.

The Prioritization Principles workgroup noticed two items that were mentioned most often at these meetings were prevention and quality of life, which have a lot of meaning in the history of the OHP. Darren believes quality of life spoke mostly to issues related to chronic diseases in trying to maintain a person's quality of life with one of these diseases or, if possible, improve it through treatment. The HSC then put together a set of 17 categories of health services to create the basic framework of the Prioritized List. The Commission is currently re-looking at these categories that the original HSC prioritized back in 1991, and will take a new look at the prioritization of new categories to determine if, in fact, the treatment of the acute fatal conditions is more important than preventive care; more important that chronic fatal diseases where early treatment can potentially avoid some unnecessary hospitalizations and complications. Those are the discussions the Commission is having.

The document also describes some of the health care surveys that have taken place since the OHP was implemented. The Making Health Policy 2000 survey and community outreach effort determined all Oregonians should have access to a basic package of health care benefits based on financial resources available for health care.

Responses in 2004 the Health Values Survey indicated preventive and primary care should be provided even when resources are constrained.

The HSC is currently just beginning their process of the final review of the Prioritized List. In statute, the HSC is required every two years to perform a general review of the rankings on the Prioritized List.

The HSC is reviewing the methodology currently in place and will be looking at the 17 categories of care to consider how they might want to see these re-ordered, if at all. The Commission will meet on December 18 to talk about the different rankings that the commissioners had come up with.

Dr. Wopat's proposal, in the re-structuring of the Prioritized List, could result in two funding lines being drawn on a single list. One line, presumably higher on the list, would be for the OHP Standard population and would include those preventive and chronic disease management

services. A line would be drawn further down the list that would look like the current OHP Plus package of today.

Darren Coffman explained there would still be a single Prioritized List for all of OHP as it is now.

Jim Russell said Dr. Wopat's proposal on prevention and chronic conditions seems like enough of a different prioritization process that you wouldn't end up with the same List with lines drawn in two different places.

Darren Coffman responded the HSC is looking at different groupings for prevention and chronic conditions. The focus on prevention and chronic disease would be for both OHP Plus and Standard. Eventually the HSC would have to review the individual line items on the List to make certain things are ranking in the way the Commission thinks they should be ranked.

The Principles Prioritization workgroup came back to the Commission and stated they felt this was a worthwhile proposal to explore and that the Commission should continue to explore it further to see if it made sense.

Dr. Lefranc asked Darren Coffman how detailed is the data on how the money is spent? He provided several examples, including keeping a person in end-of-life care, on a vent. He noted that it becomes very tricky to take someone off a vent and asked if the Agency kept track of where the money is being spent on those types of end-of-life cases. If so, the state would have better information to support efforts to prevent medically unnecessary expenses.

Darren Coffman responded that the HSC is certainly discussing those types of situations. OMAP is keeping the databases in terms of utilization. In the case of end-of-life care, it is particularly hard to define those types of situations. There are no specific codes relating to end-of-life care, and Darren didn't believe staff could check from a claims standpoint that a person was kept on a ventilator because of family decisions.

Action item:
Darren Coffman will keep the Committee updated on the work of the Prioritization Principles workgroup. Rick Wopat will also talk about the Health Services Commission's work at the next Committee meeting.

Racial and Ethnic Health Disparities

Bob DiPrete said for about two years the state had a task force on racial and ethnic health that was created by Executive Order. The final report on that group's work was distributed to Committee members. That task force focused on six priority areas:

- HIV/AIDS
- Diabetes
- Asthma
- Lead Poisoning
- Alcohol abuse/Drug abuse
- Access to appropriate care for those with insurance.

The task force believed that the first five areas are health issues that a lot more could be done about than was being done to provide services to people in racial and ethnic communities. The sixth more general issue was how to assure adequate access to treatment for Oregonians with physical and mental health coverage. Adequate access was defined as medically appropriate care provided, when necessary, by culturally competent providers in a suitable setting. The motivation for this was the realization that for many racial and ethnic communities in Oregon, there were disparities in health status, health treatment and health outcomes. The problem is that a lot of people in these communities start off with a worse health status than other Oregonians, and they and have greater difficulty getting treatment, whether they're insured or uninsured, that's effective for the conditions that need to be treated and is culturally sensitive. That includes sufficient interpretation services. Even when these clients receive treatment, often their outcomes are not as good as other similar populations with the same health problems.

The report reviewed information that was available in order to make sense of what was going on which included both clinical studies and information about who's eligible for coverage, who's getting coverage, who's getting into treatment, what treatment they're receiving. A lot of the report gets at systems and process changes that will be necessary to make the information available to support better-informed recommendations and policies to address these problems.

The Task Force on Racial and Ethnic Health no longer exists but Bob DiPrete noted that it is important that the Medicaid Advisory Committee understands the work that was done, what the recommendations were and why it's still important to be thinking in terms of these disparities and what can be done to address them. He hopes that at a future meeting, this can be addressed in more detail, and the Committee can make this part of the process of evaluating what kinds of changes they might recommend to make Medicaid more effective for all Oregonians.

Carmen Urbina said that other overarching issue the Task Force looked at was access. The accountability piece was also discussed in length. She indicated it was a dedicated Task Force who produced an incredible amount of work. What is being seen now, even after this report, is that Oregon is 10 years behind many other states in addressing racial and ethnic health disparity issues.

Dr. Lefranc asked if the Oregon Health Plan pays for interpreter use.

Lynn Read answered no although there is the responsibility for the delivery system, via the hospital, physician, managed care plan to insure that appropriate interpreter services are available. In the fee-for-service environment, for example, OMAP does not pay for a medical interpreter. It is up to the medical community to see that this need is met. In various past budget-building processes, OMAP had actually put together a policy package that would include a medical interpretation component for fee for service and for managed care that would be very explicit, but interpreter services has never made it into the Governor's Recommended Budget.

Dr. Lefranc indicated there is a lack of knowledge about the need to provide cultural components of health care and that the medical community really hasn't moved from the mentality of 'us' and 'them'. Dr. Lefranc has applied for a grant to work on issues of diversity and to do an evaluation of all the 23 clinics that Providence sponsors on how the physician sees and the clinic approaches diversity. What he has learned so far:

- Lack of interpretation is widespread
- Clinic employees do not represent the population they are serving; namely, clinics do not hire employees that are in the minority population at the same ratio
- Lack of accurate medical information in the language and the culture

- Ignorance of cultural issues affecting health care
- Lack of funding - a large portion of the Medicare patients are Latinos. Many only speak Spanish but the state does not reimburse interpretation.

Dr. Lefranc recommended an excellent book, "The Working Poor – Invisible in America" by David Shipler. There is a chapter that specifically talks about health care and all the consequences of people who do not have enough insurance and how poverty and the lack of medical care, even Medicaid, perpetrates the cycle of poverty. He would encourage people to read it.

Action item:
Tina Kotek suggested the Committee prioritize the racial and ethnic disparity issues at a greater degree to make sure that the Committee as a public body is moving forward on effectively addressing those issues. She asked members most familiar with the report to pull out the Medicaid policy related issues.

Public Comment

Bruce Bishop, appearing on behalf of the Oregon Association of Hospitals and Health Systems, wanted to underscore the importance for the Committee of what Darren Coffman was presenting as a fundamental re-examination of the principles of the Oregon Health Plan and the Prioritization of Health Services. In his view, over the last years, the Health Plan has become a prioritized list of covered benefits, not of health care services, and he believes there is substantial difference in the results that derive from that. The preamble of Senate Bill 27, addressed prioritized services not prioritized benefits. He believes the state has gone away from that orientation.

Bruce Bishop would urge the Committee to look very carefully at the three-line statement that Darren Coffman included in the packet that describes what Senate Bill 27 said the prioritization was about and decide if they think that still represents good policy for Oregon. If it doesn't, the policy would need to be changed. If it does, we would need to make sure that's the direction we want to go.

Dr Lefranc asked Bruce Bishop what does he suggest the Committee move forward on.

Bruce Bishop believes the Committee should look carefully at the underpinnings of the OHP including the law and the policy reflected there to decide if making the kinds of changes that Darren Coffman described can be done within that policy or will it require a new policy statement to carry it out.

Next Meeting
The next Committee meeting is scheduled for December 1st, from 8:30 am to 11:00 am in Hearing Room 50, State Capitol, 900 Court Street, NE, in Salem.

Meeting adjourned.

Medicaid Advisory Committee/Joint Public Hearing
September 8, 2005
Hearing Room 50, State Capitol

Present: Bruce Bliatout, Elizabeth Byers, Kelley Kaiser, Tina Kotek, Carole Romm, Jim Russell, Rick Wopat, MD

Absent: Donna Crawford, Michael Garland, Yves LeFranc, MD, Carmen Urbina

OHPR: Bob DiPrete

OMAP: Lynn Read, Allison Knight, Roger Staples, Mary Reitan, Dar Nelson, Cheryl Terry

Tina Kotek, serving as new Committee co-chair, opened the meeting and asked the Committee for introductions.

Minutes from the last Committee meeting on July 19 were approved as written.

Tina Kotek explained that the purpose of the public hearing today is to address direction from the Legislature on benefit cuts to the Oregon Health Plan (OHP) and the Special Appropriations bill relating to FHIAP and OHP funds.

Bob DiPrete further explained that the two items to be discussed must be addressed promptly by state agencies. He asked that testimony provided today be focused around those two issues.

Public Hearing

Lynn Read, Interim Administrator with the Office of Medical Assistance Programs (OMAP), provided context on some of the actions OMAP has taken since the legislative session ended.

OMAP will be pursuing several waiver amendments coming out of the legislative session which will require careful consideration and planning. Timeframes have been set in statute for submission to the federal government on some of these actions.

Lynn Read stated that OMAP wants to engage the public in the development of a waiver amendment and seeks public input. A variety of meetings have been held prior to today to review policy proposals and to gather input with stakeholders, advocates, tribal representatives, providers, health plans and associations targeted to specific areas that are under consideration. The Internet has also been used to gather questions and input from a broader audience.

There are three waiver amendments coming out of the 2005 legislative session.

The first is related to OHP Standard premiums. The waiver amendment was submitted to Centers for Medicare and Medicaid Services (CMS) on September 2nd. Senate Bill 782 requires that the amendment be submitted within a 30-day period. Provisions of the bill reflect most of the Medicaid Advisory Committee's (MAC's) recommendations made in September 2004 related to premiums for OHP Standard. The waiver amendment requests approval to:

- Exempt clients from paying premiums if their income is at or below 10% of federal poverty
- Eliminate the 6-month period of ineligibility that clients have if they are not current on their premium payments
- Allow an extended grace period of up to six months for payment of premiums
- Require clients to be current on premium payments at the time at which they reapply for another six-month eligibility period.

Two questions surfaced:

1) Does Department of Human Services (DHS) need federal approval?
2) If so, does it have to be a waiver amendment?

After discussions with the Department of Justice and CMS, it was determined that the OHP Standard premium restructuring would require a waiver amendment. Lynn Read is optimistic that CMS will approve this waiver amendment, but it is not known how long this will take.

Another issue surfaced in the discussions, how monthly income fluctuations during the certification period and at reapplication will affect the exemption from or requirement to pay premiums. OMAP will be working to resolve this prior to implementation and administrative rules for that program change.

The second waiver amendment relates to benefit changes. There are several benefit changes that will be submitted in the waiver amendment. The amendment needs to be submitted in October in order to meet the 60-day requirement in the legislative bill, House Bill 3108. House Bill 3108 provides the department with the authority to implement adjustments to health services that are funded in the Legislatively Adopted Budget (LAB). The Governor's Recommended Budget (GRB) included a number of proposed reductions for the OHP Plus program, totaling $162 million. The Legislature backfilled some of the items in the Governor's proposed budget, including some dental cuts for OHP Plus adults. The Legislatively Adopted Budget (LAB) made additional reductions, bringing total reductions to $185 million.

The four proposed changes to be discussed today, which total $15 million in reductions, are:

1) Vision benefits - elimination of routine exams and glasses for non-pregnant adults age 21 years and older. Exceptions, such as lenses to restore vision normally provided by the natural lens of the eye, when the organic lens has been removed, or due to specific medical conditions, were discussed with stakeholders.
2) Dental benefits: The budget is short about 12% of what it would take to provide a full benefit. OHP Plus adults (not pregnant women) would receive a reduced basic benefit. Most advanced restorative procedures (molars and crowns) and dentures for new extracted teeth would be eliminated. This reduction would affect 123,000 adults.

   Standard clients would continue to receive emergency dental care.

3) Hospitals: The Governor's Recommended Budget (GRB) limits hospital days to 18 per person per year for adults over age 21.The reduction would not apply to Medicare beneficiaries, Type A and

B hospitals, or to fully capitated health plans. It would only apply to clients in the fee-for-service system.

In discussion with stakeholders, the following issues were raised:

1) Clients in different parts of the state or in different delivery systems would have differential or unequal benefit.
2) Persons with chronic illness who are in and out of the hospital would be affected.
3) Hospitals would still provide care but cost shift to other payers.

Suggestion of an alternate idea surfaced in the stakeholder meeting that would modify the DRG outlier formula for paying DRG hospitals with 50 beds or more for exceptional cases in order to realize the savings needed to operate within our budget without implementing the complex initiative of tracking bed days. OMAP is currently exploring this idea.

4) Pharmacy: One of the reductions in the Governor's Recommended Budget that was not backfilled was over-the-counter drugs. Stakeholders were presented in discussions with three guiding principles:

- Coverage for a drug should not be eliminated if there was no clinical alternative and the elimination of that drug would likely result in deteriorating health, increasing the need for future services.

- Drugs should be retained if they are less expensive and are a clinically effective alternative to legend drugs.

- Over-the-counter drugs should be retained if there is strong evidence that they promote health or otherwise contribute to the prevention of future adverse health conditions.

OMAP wants to ensure that the proposal would be implemented in a way that ensures clients receive medications for covered conditions, and that takes particular note of drugs that might be utilized by clients with co-morbid conditions.

Some ideas that surfaced in stakeholder meetings:

- Eliminate over-the-counter and legend vitamin products, except prenatal vitamins, fluoride for children, vitamins B6, 12 and D, calcium, iron, potassium and phosphate.

- Eliminate over-the-counter and legend hemorrhoid therapy drugs and over-the-counter and legend topical steroids.

Rick Wopat asked Lynn Read to explain the statement in House Bill 3108 that gives OMAP the authority to alter the benefit package and what the limitations are around that authority?

Lynn Read responded the limitations are broader than some would like but also limited. OMAP can implement the administrative rules to allow them to live within the budget for this budget period. OMAP has focused on doing that in the four reduction areas discussed.

Last legislative session, House Bill 2511 placed constraints in terms of changing the benefit package and even on the Emergency Board's ability to make changes during the interim period. House Bill 3108, this session, gave OMAP the flexibility to implement reductions that were not funded in the Legislatively Adopted Budget.

Elizabeth Byers thanked Lynn Read for her outstanding work on the Oregon Health Plan. She then asked whether state employee health coverage includes vision, dental, hospital and pharmacy services.

Lynn Read responded that state employees do have those benefits, but with some limitations and cost sharing requirements. She also noted that her ability to address cost sharing requirements is greater because of her income as a state employee than it would for OHP clients.

Tina Kotek asked if the department is prepared to take action to expedite the waiver request on premiums.

Lynn Read responded DHS has been engaged in ongoing conversations with CMS but that OMAP can't implement prior to receiving CMS approval. This waiver request is not as controversial as some others, but federal approval is not imminent.

Tina Kotek added that the Committee would appreciate anything OMAP can do to help that along.

Tina Kotek asked if any of the other reductions for DHS, other than the $15 million, required a waiver amendment.

Lynn Read responded of the larger $185 million not funded in the Legislatively Adopted Budget, a number of those reductions can be implemented without a waiver amendment. Graduate medical education reimbursement would not require a waiver amendment, nor would the $131 million related to the DRG hospital component of FCHP capitation rates. The $12 million associated with not providing cost-of-living increases for fee-for-service providers is another example that would not require CMS approval.

Tina Kotek requested that the Committee see a copy of the updated list reflecting the reductions and asked Lynn Read to give a broad breakdown of the $15 million reduction.

Lynn Read indicated the following proposed benefit reductions are shown in Total Funds:

- Hospital - $2.4 million
- Pharmacy - $2 million
- Vision - $6.6 million
- Dental - $4.4 million

Tina Kotek asked if the administrative cost was included when DHS calculated the savings.

Lynn Read responded there is a consideration of additional costs from administration of any particular item. In some cases, staff will absorb the workload. DHS has a computer system to handle to 18-day hospital limits in place already, as there was a limit on hospital days prior to the implementation of the OHP. System modifications will probably be minimal to re-establishing it.

Rick Wopat inquired about the size of the impact in terms of money for the GME reduction and how many people would be affected with the vision, hospital and pharmacy benefit reductions.

Lynn Read said that graduate medical education (GME), at $9.3 million Total Funds, was identified as a reduction in the Governor's proposed budget, and probably 85% of those payments would have gone to OHSU.

The reductions in dental and vision benefits apply to all OHP Plus adults, those adults over 21 years of age, and could impact 123,000 individuals. Lynn Read did not have numbers of how many were in dental users.

The reduction in over-the-counter drugs applies to the entire Oregon Health Plan (OHP) population, including Medicare beneficiaries. Over-the-counter drugs are also not a part of the new Medicare drug benefit which will be implemented in January 2006.

Lynn Read did not have specific numbers on the number of people impacted by the hospital-day limitation reduction. Clients enrolled in managed care would not be affected, and of the remaining 100,000 in fee-for-service, some are receiving care from Type A & B hospitals that would not be impacted. Lynn believes that probably 80% are receiving care from the larger hospitals that would be impacted. The 18-day limit would apply to persons, who have during the course of a year, used more than 18 days, and then have a hospital admission.

Rick Wopat requested that actual numbers used in pricing be provided to the Committee. Lynn Read said she would try to provide that. {Sue – please remind Lynn that she should provide this if possible, or explain that it's not possible and let the MAC know what information on pricing these options is available. Thanks.}

Elizabeth Byers inquired about the deadline for submitting the benefit reductions amendment to CMS.

Lynn Read said, in order to meet the 60-day deadline imposed by the Legislature, the waiver amendment must be submitted to CMS by October 28. DHS hopes today's public hearing will provide input in terms of developing the waiver amendment request.

Elizabeth Byers asked why the department focused on cuts for the fee-for-service population.

Lynn Read responded that a number of reductions and efficiencies have already been realized in the managed care delivery system. A reduction in capitation rates to fully-capitated health plans, scheduled for January, reflect some of the efficiencies that have occurred in that system and their ability to coordinate and appropriately deliver health care. There has not been a comparable impact in the fee-for-service system.

Elizabeth Byers asked if a person enters the hospital, and for some reason it takes longer than 18 days for their care, who is responsible for the rest of the payment.

Lynn Read answered that the whole stay would be covered regardless of the days.

Dick Stenson asked if managed care was available in all communities.

Lynn Read said managed care is not available statewide, but that DHS is working to expand managed care availability into geographic areas that either do not have a managed care plan or don't have the capacity to serve everyone in that community. In communities where there is adequate managed care, some people are not enrolled as the plan may not be appropriate for their care for one reason or another.

The MAC then began hearing public testimony.

Testimony from Eli Jenny:

Eli Jenny voiced her concerns about how the dental and vision reductions would impact those who have absolutely no money to pay for glasses or dental care. She believes that it's penny-wise and pound-foolish logic. People, who have dental issues, will go to the emergency department, in turn, costing the state a lot of money. Those with vision issues that have not been corrected may be involved in auto accidents, trying to travel to the store for food or prescription drugs. Eli stressed that she did not believe it is logical or humane to punish the most vulnerable and take away what used to be a given so that they have to fight to receive benefits or services.

Rick Wopat: Thanked Eli Jenny for testifying at the Public Hearing and for the work she has done with Oregon health Action Campaign over the years. He then challenged all at the Public Hearing to go beyond simply stating what is wrong and to suggest what Oregon might do differently to make things better.

Tina Kotek reminded the public hearing that the Medicaid Advisory Committee is an advisory committee whose role in the hearing is to gather public testimony and discuss the relevant issues in order to come to a consensus on how the state might best proceed with the amendments to be proposed to CMS. Tina also said the Committee is looking for additional members of the MAC, including Medicaid recipients.

Testimony by Michael Volpe:

Michael Volpe, a member of the new People with Disabilities Advisory Committee, expressed appreciation to all those who came to the hearing to work on what is obviously not the greatest situation. He believes one of the outstanding parts of the OHP is to use prevention to avoid higher costs in the future. Michael had concerns regarding the fee-for-service cuts is that there are a number of people in counties without managed care that will be unfairly hurt by the cuts proposed.

Testimony by Michael Shirtcliff:

Dr. Michael Shirtcliff is President and Dental Director of Northwest Dental Services, a group representing 300 dentists who serve 75,000 folks on OHP dental. He represents most of the dental care organization directors supporting the proposed cuts. He mentioned the cuts do come with consequences but what they have tried to do is keep as many people covered as possible, to cut benefits instead of people, and pay providers who will continue to participate. Prevention is stressed in order to avoid high costs. Dr. Shirtcliff suggested that pregnant women be included in the same benefit package as for OHP Plus folks. Nothing proposed in the cuts would prevent a pregnant woman from having a healthy baby.

Dr. Shirtcliff recommended that coverage be eliminated for posterior stainless steel crowns on the four primary incisors teeth for children five years old and older.

Dr. Shirtcliff said the proposed reductions wouldn't be implemented until July 2006, the last year of the biennium. He asked for clarification on whether the Emergency Board would be able to make up the difference if the proposed cuts do not bring in the savings needed.

Elizabeth Byers asked Dr. Shirtcliff what are the employment options for a person if their teeth are not in place, or decayed.

Dr. Shirtcliiff responded that the cuts being proposed would not prevent someone from getting a job. He also reminded that now we're on the verge in OHP dental of not being able to go any further. The money has been stretched as far as it will go.

Carole Romm asked for clarification between the children's, the pregnant women's and OHP Plus package.

Dr. Shirtcliff indicated there are currently three benefit packages: children, OHP Plus adults and OHP Standard. A fourth package is being proposed for OHP Plus adults and would give them a reduced dental benefit, eliminating crowns, no replacement dentures, no root canals, elimination of some periodontal services. He suggests that pregnant women receive the same reduced benefit package as OHP Plus adults.

Rick Wopat thanked Dr. Shirtcliff for his commitment to and being a steadfast supporter of the OHP. He suggested that Dr. Shirtcliff's recommendations, around restorations for children at ages 4 and 5, go to the Health Services Commission.

Testimony from Hospitals:

Panel #1: Gwen Dayton, Marvin Hass

Gwen Dayton, Interim Director and General Counsel, for Oregon Association of Hospitals and Health Systems, highlighted the Hospital Association's concerns that fall into two categories: process and policy decisions. She indicated there has been no legislative hearing or public hearing on these reductions. When House Bill 3108 was passed, Senator Bates indicated there is nothing in the budget itself specifically that directs that hospital or prescription drug coverage be limited or reduced.

Ms. Dayton indicated that the Hospital Association has not received information from the department about the need for the cuts or about the impact on both hospitals and patients from those cuts. The limitation on hospitals days will inappropriately impact certain areas of the state and certain patient populations, primarily the elderly, the chronically ill. She expressed concern that a similarly situated patient in one county that has significant managed care will receive a much richer benefit than a similarly situated patient in a county that does not have managed care.

The Hospital Association has significant concerns about no reimbursement, other than the $25 triage fee, for an emergency department visit that is for a non-emergent condition. They are concerned that the administrative cost to administer the triage would overwhelm any cost savings from failure to reimburse hospitals. People are being driven to the emergency department for care they cannot receive anywhere else.

The Hospital Association has not received any information from the department on the impact of changing the DRG rates, and don't believe this will actually result in cost savings.

Eliminating funding for graduate medical education was believed to be poor policy, by not training new physicians, will have long-term consequences for the state.

Testimony – Marvin Haas

Marvin Haas, Senior Vice President of Administration and Finance for Asante Health Systems, believes this is a definite fairness issue for both the patients as well as providers. Asante Health Systems serves two hospitals, one in Medford, one in Grants Pass; one that's highly managed care, one that's hardly managed care at all. All patients are treated equally at both hospitals.

Fee-for-service patients would not be covered if they had a hospital admit after the 18th day. From a provider's perspective, they would not know how to account for the number of days if the patient received care at another hospital.

The benefit reductions would also have in impact on federal match. One of the reason provider taxation was created was to maximize federal match.

Mr. Haas suggested a couple of alternatives for savings:

- Taxation – increase the provider tax rate slightly, therefore, not affecting providers as far as how evenly or unevenly they are being hit. By doing this, it would eliminate the administrative work in trying to manage the 18 days and tying to manage all the other cuts.

- Small reduction in the base DRG payment rate

Rick Wopat commented to Marvin Haas that in his area, he doesn't see a managed care plan, and suggested the hospitals work together in that area to cooperatively create one.

Marvin Haas responded that there were managed care plans in the past but they lost so much money they felt the risk was too concerning.

Elizabeth Byers shared her concern that taking away the ability to have resident medical students that see indigent people, people with no insurance, people who are underinsured and people on the OHP, how would that benefit the system.

Gwen Dayton agreed and said it was ill advised.

Testimony from Second Panel: Bradley King, Gordon Edwards, Steve Gordon

Testimony – Bradley King

Bradley King, on behalf of Oregon Health Sciences University (OHSU), addressed each of the four major areas of reduction:

18-day annual limitation for adult fee-for-service patients: The proposed action will reduce payment for services to the sickest covered beneficiaries, which is contrary to the prioritization of services under the OHP. Because of long inpatient stays generally being incurred by the most acute patients, the impact of this change will fall disproportionately on Oregon's few tertiary referral centers, those that see these patients most frequently. OHSU has calculated that they would lose approximately $1.6 million due to reduced payments. OMAP has shared that system-processing difficulties

may mean that it may pay whichever hospital's bill is received first regarding of when the patient was actually served. A hospital, assuming a patient's stay would be covered, because they've had no other stay that year, may not be paid at all because it was late in getting its bill in.

Emergency Department (ED) Efficiencies – OMAP's proposed methodology should also include consideration of secondary diagnoses in cases where significant cost is appropriate to rule out other inflictions. ED services, when the condition is found to be non-emergent, should be reimbursed at least at a rate to what would be paid in a private physician's office which is substantially more than the $25 fee proposed for assessment and triage.

Elimination of Graduate Medical Education payments – During the recent session, the legislature restored the proposed cuts for graduate medical education in the Governor's proposed budget. Now to turn around and eliminate funding through this vehicle flies in the face of that specific legislative action. The bulk of the savings would come from Oregon's only academic medical center. OHSU may be faced with the choice of raising each medical school student's tuition by approximately $7,900 per year or reducing the class size by 12 students to offset that cost.

Conversion of unique DRG Weights to a Medicare Standardized Weighting process Most of the re-weightings affect neonatal care. Medicare developed its neonate case weights from a limited sample of Medicare cases. Medicare serves primarily the elderly and does not have in its database many neonate cases. Oregon put through a team of agency/hospital/physician consultants to develop the unique DRG weights, and Mr. King stated he doesn't understand why they want to abandon that work. Also, OHSU believes that OMAP wouldn't realize any savings from the re-weighting, as more and more cases would fall into the outlier payment category and receive reimbursement on that basis.

Bradley King explained Oregon's unique DRG (Diagnosis Related Groups) and Medicare's DRG weighting systems.

Elizabeth Byers asked how the change would affect moms who come in the hospital and deliver two-pound babies.

Bradley King responded OSHU does not turn those babies away. Because the hospital stays are longer for those babies and higher costs incurred, the

hospital will receive a formula-driven additional payment based upon an outlier status which will bring the reimbursement closer to the unique Medicaid weight of 18. {Somewhere about here Rick Wopat pointed out that the MAC was briefed on proposed DHS budget cuts in May of 2005 and made recommendations regarding budget "add-back" priorities at that time. It was an important point and we should add it, even if we're not certain exactly where it should go. It was either during or shortly after Gwen Dayton's testimony.}

Testimony – Gordon Edwards

Gordon Edwards, Director of Finance Operations at Legacy Health System, shared concern about the proposed reductions and the messages these cuts are sending to the public.

The proposed cuts translate into a reduction of roughly $5.6 million annually for Legacy Health System hospitals.

18-day Annual Hospital Limitation. The OMAP fee-for-service patient is substantially sicker than its managed care counterpart and will be hurt by this.

Emergency Department (ED) Efficiencies. The proposed cuts contradict the physician's judgment in determining a treatment plan. The assessment of a non-emergent condition is based on the final diagnosis and not the condition of the patient that presents in the emergency department. The proposal does not allow the hospital to direct the patient to another setting before care is provided but rather penalizes the hospital for providing care as ordered by the physician. ED efficiencies' reductions disproportionately impact the safety net provider, the hospital emergency department. Clinics of last resort do not have the capacity to care for these patients, and the emergency department remains the only after-hours access point.

Elimination of Funding for Medical Education. Is it in our best interest to look to outside recruitment programs to attract physicians rather than fund our own programs? Legacy Health System believes the answer is a local program.

DRG re-weighting modifications focus on rehabilitation and NICU services. Legacy Good Samaritan Hospital, with its Rehabilitation Institute, and

Legacy and Legacy Emanuel Hospital, with its level 4 NICU, would be disproportionately impacted by the reduction. Medicare does not cover children so the analysis is flawed on the lack of appropriate data.

DRG hospitals have financed the hospital benefit for 25,000 OHP Standard enrollees. These proposed cuts are focused solely on DRG hospitals that have already made a significant financial commitment to the state. Alternatives need to be found that won't erode the financial viability of the health care providers.

Testimony – Dr. Steve Gordon

Dr. Steve Gordon, representing Providence Health System, shared his concerns about the proposed cuts to the Medicaid program, specifically on issues of quality and access.

18-day limitation of hospital stays – When patients come to the hospital, they will receive care, but when the care is outside the reimbursement provided by the state, the cost of that care will fall to other payers of care. There will be additional cost shifting both the providers and hospitals.

Emergency (ED) department efficiencies – When patients come to the emergency department, it is because they are the provider of last resort, and the community safety nets are gone. Patients will be provided excellent assessment, but again without reimbursement, there will be cost shifting.

Graduate Medical Education – Many physicians do come to Oregon to practice and they come here for non-financial reasons, for the quality of living in Oregon and also for the spirit of innovation and collaboration within the community. Nothing will disproportionately impact the poor and the vulnerable in this state more in the long term than to have an insufficient number of high quality physicians in the short term.

DRG payment weight factors – Oregon is a leader nationally in neonatology and NICU care, reducing the number of babies with chronic lung injury, chronic brain injury, long-term disabilities. It is the prevention in those outcomes that Oregon has had great successes.

Dr. Gordon added that Providence looks forward to participating in an active fashion to make the best of what we have and move forward.

Carole Romm inquired about the ED assessment fee. CareOregon developed a program of ED assessment, which was a nurse review of the ED chart after the diagnosis fell out to determine whether the emergency room admit was truly emergent.

Steve Gordon agreed that having a nurse review the chart would be a much better approach to determining whether a patient's emergency room visit was truly emergent than using one ICD-9 code, regardless of any secondary diagnoses, to rule out anything but an assessment fee. He also suggested there might be pairings of primary and secondary diagnoses to indicate whether or not it was appropriate for the patient to present to the emergency department.
Speaker {Was this a MAC member? If so, can the member let us know who you are? If not, let's just say "The point was made that there is nothing …..": The issue is there is nothing allowing the emergency department, at the time the patient presents, to actually direct them to a different point of access and a different place of care. The hospital essentially is the one that treated the patient, based on the physician's judgment of what needed to be done, and then just doesn't get paid.

Rick Wopat indicated his managed care plan has had success by looking at the presenting condition to determine whether diagnostic testing was indicated or not, based on a screening exam. Dr. Wopat asked the hospital representatives how do we prevent the patient from going to the emergency department; how do we manage their disease so they don't need 18 days in the hospital; how do you, as systems, help to avoid those ED visits and hospitalizations by providing primary care?

Steve Gordon responded that Providence has tried a variety of vehicles to make access available to clients. Providence is proud of the breadth and depth of primary care services throughout their sponsored clinics, both in Portland and throughout the state, though some of their facilities don't operate in the evening hours or overnight when these patients are presenting to the emergency department. There are also times when the willingness to accept Medicaid patients among primary care physicians just isn't there, and there is no alternative to direct them to.

Testimony – Jane Myers

Jane Myers, representing the Oregon Dental Association, provided written testimony and asked the department to provide the CDT codes used to describe the proposed benefit package. She indicated the proposal on dentures was unclear and asked for clarification of the proposal.

The Dental Association is reluctant to support eliminating cast-frame partial dentures because they are a little sturdier and often serve for many years with little adjustment. The design of the acrylic partial is also important because poor design can contribute to periodontal problems, being gum disease.

Elimination of porcelain crowns on anterior teeth is a concern as usually there is no substitute for porcelain fused to metal crowns.

Jane Myers asked for clarification of two parts of a separate proposal being offered by the dental care organizations:

- Pregnant women have the same set of benefits as other OHP Plus adults. OMAP's proposal would cover pregnant women for more services in order to ensure healthy birth outcomes.
- Limit prefabricated stainless steel crowns on all primary, first or baby teeth, incisors on children who are five years old and over. This proposal needs to be specifically limited by tooth to just incisors.

Ms. Myers said it would be helpful to ensure that code D2999 is included so dentists can provide an unspecified restorative procedure, by report, when needed.

Testimony – Deborah Loy

Deborah Loy, Director for Capitol Dental Care, serving 100,000 OHP clients, added over the past five years due to economic issues, the Oregon Health Plan has been under a lot of scrutiny and changes, especially for the dental program. Many dental services are ranked high on the prioritized list of health services. She indicated that when the OHP started, people covered under this plan, let those in leadership know dental was a very important benefit for them. They have maintained that dental is an important benefit through surveys over the years.

Ms. Loy stated in her dental care organization there are 15 procedure codes that constitute 60% of their payment activity, primarily primary care and prevention care. Only 40% of the codes end up being all the other.

Ms. Loy recommended keeping one OHP Plus package, take services and put limitations on them that make sense and that hopefully don't affect primary care or prevention care. She proposes putting age restrictions on a service; redefining the service with better criteria, and using more restrictive criteria in order to implement those limitations earlier than July 1, 2006. Spreading the time element would give the dental care organizations more time to get to the proposed funding level. Some of the limitations can be handled through rule revision, and not require CMS approval.

The OHP has about approximately 91% of its clients enrolled in dental managed care. She suggested that a dental representative be included as a member of the advisory groups as dental is an important part of health care.

Testimony - Cedric Hayden

Cedric Hayden, Dental Director in Hayden Family Dentistry, serving 21,000 OHP clients, said his dental plan has enrolled clients since the inception of the OHP in 1994, and that the dental care organizations (DCOs) have been good partners with the state during the entire period of time. Whenever there was a cut or elimination of services, the DCOs cooperatively stepped up and said they could make the program work. They receive $17 per person per month capitation for services provided which is very cost effective.

The DCO's also provide dental care for 25,000 OHP Standard clients, at no cost to the General Fund. The program is funded by provider taxes, premiums and federal match.

Dr. Hayden concluded that the DCO's request is for adequate and stable funding so this program can continue and meet the constraints of the prioritized list.

Tina Kotek asked the dental panel if they had any numbers on how many children would be affected by eliminating crowns on incisors and how much money would be saved. She felt it was important to place limitations on

some services so they could implement them sooner and asked if there was any additional information in terms of costs and savings.

Deborah Loy responded that the OMAP dental policy analyst has submitted a list of procedures to determine the savings to the actuary for the Oregon Health Plan. Those numbers are not back yet. In her DCO, of the 15 procedures they pay for as a plan, primary teeth stainless steel crowns account for the one of the largest costs.

Tina Kotek asked Ms. Loy for clarification on pregnant woman.

Deborah Loy explained what Dr. Shirtcliff was testifying to. The benefit cuts for OHP Plus adults would not take away from the primary directive for the pregnant woman that is to basically ensure prevention services and/or disease-oriented services that would affect her health or the baby's health. Whether a pregnant woman has a replacement denture isn't going to affect her or her baby. The treatment of any infection or disease process is going to. Children would have the basic benefit package. Some services for children because they are the mandatory population would be covered by age limitations.

Speaker: asked if a person has 3 molars pulled, under the new limitations as an adult would that person not have any restoration?

Cedric Hayden responded the proposed benefit would be that a person could have dentures made once but would not be entitled to a multiplicity of dentures.

Deborah Loy added that if a person has four or more missing back teeth and it impedes their ability to masticate their food, they would qualify for a partial denture. Current coverage includes cast-frame partials that are being recommended for elimination. The dental plans have asked for consideration of the acrylic partial that would be in the same coverage guidelines that applies to the cast-frame partial.

Jane Myers reiterated that it becomes really important for the dentists and the people carrying the program to know what codes are in the program. If you're creating guidelines, they must be very clear so they are not misinterpreted in the dental office. The dental plans will need those numbers to be part of the package that OMAP finalizes.

Testimony – Senator Jackie Winters and Senator Ben Westlund

Senator Winters stated she did not support House Bill 3108. Last session, the legislature faced daunting issues on how to provide medical care and dental services to citizens of the state. A package was put together, with help from the hospitals and managed care organizations, in which the providers agreed to tax themselves in order to match those dollars with federal dollars to provide funding for the OHP Standard program. She commented that it was troubling to her to come through this session where not only have we reduced or cut the population, but we reneged on an agreement that we made with others who were partners in trying to serve the citizens of the state. She said, that it is an issue that, we as policy makers should have turned and dealt with the funding, dealt with what population from a policy standpoint to be served and not have and passed it off on to you. It is the legislature's responsibility. She said policymakers need to begin talking about what it is we want to provide as a service in this state. We've now bigger issues that we need to begin addressing, and we need to address them now.

Tina Kotek thanked Senator Winters for her leadership.

Testimony – Senator Ben Westlund

Senator Westlund added to Senator Winters' testimony that it's the legislature and our overall lack of understanding of the health care system that is truly responsible for the necessity of the department having to make these cuts. He gave a brief history of how we got here today. In November 2002 the Legislative Emergency Board made some bad health care decisions. The error was compounded during the 2003 session when the Legislative Emergency Board was statutorily prohibited from reducing services and benefits to OHP clients. During the most recently completed legislative session, there were major budget reductions to be made, and the legislature crafted House Bill 3108 that left much of the decision making to DHS.

Senator Westlund stressed to the department and committee members to listen to and work with the providers who are responsible for implementing the reductions. The department will make the cuts but the providers will be responsible for implementing them. Ask for their input and value it. He

cautioned the department to not, for the ease of administration and efficiency, make these cuts in a vacuum.

He commented that it is a misconception to believe the OHP is failing. It is not failing. It works, and prioritized managed care has saved the state countless millions of dollars and provided her citizens more access to better care. If we continue to under-fund the OHP and health care in this state, the crisis of health care will crush us all.

Rick Wopat expressed appreciation to both Senators Winters and Westlund for coming to the hearing. Dr. Wopat agreed with their comments that there is not enough money, that there's not enough gas in the tank, but the challenge before us is where do you go from here to stretch dollars?

Senator Westlund responded that the decision-making process that went on during this session did not serve Oregon's citizens well. He again stressed that the department and committee members listen to the people, the DCO's, the hospitals, the managed care organizations, and providers who are going to be responsible for implementing these cuts.

Senator Winters added she believes that it is the legislature's responsibility to say this is what we can afford and what we're going to provide, but not to put it off to someone else, which is what the legislature did. That is the reason she did not vote for House Bill 3108. Senator Winters agreed with Senator Westlund that the department and committee should listen to the providers.

Tina Kotek thanked the senators for their comments. Tina questioned why only the $15 million in benefit reductions was being discussed today when there is another $170 million reduction that will also have to be made.

Carole Romm inquired whether we are limited to the proposed benefit reductions or do we have some leeway around what the specific proposals are, and what's the timeline?

Bob DiPrete responded that part of it is timeline driven, by the application processes or decision-making processes with CMS.

Senator Winters commented that she believes we've forgotten the CMS piece. CMS needs to agree to the recommendations being made. There is

no guarantee that CMS will approve the benefit reductions being submitted. Members need to keep that in mind. It's not a time to blame one another. There are important health care issues that need to be addressed. She said she will continue to work on these issues and plans to reconvene the summit she started last year.

Lynn Read indicated that a big piece of this in terms of decision making and building the Governor's proposed budget was not only looking what the impacts are on clients, what the impacts are on our ability to get services to clients in terms of the provider community, but what is our ability to get it approved by CMS. Vision and Dental for adults and over-the-counter drugs are optional services in a traditional Medicaid program. DHS thought those services had a better chance of gaining CMS approval. The 18-day hospital limit concept was something CMS had previously approved prior to implementation of the Oregon Health Plan. The reductions were priced to assume that they wouldn't take effect until July 1, 2006, because of the long expected dialogue with CMS on whether or not they would grant approval. If CMS does not approve the reductions, DHS will be going to the Emergency Board, with a departmental rebalance. If there is no surplus in the Emergency Board and the department cannot affect these cuts, they will have to propose other actions. A plan has to be delivered to the Emergency Board.

Senator Westlund asked if the Committee would consider other options not being proposed by the department.

Lynn Read responded if the other options are benefit reductions, they would have to be submitted to CMS within 60 days of enactment. The department would have a little more flexibility if we submitted something that isn't a benefit reduction, but we would need to have agreement on that soon. The waiver amendment must be submitted to CMS by October 28.

Tina Kotek inquired if the department actually had two plans, one that has no benefit reductions and doesn't require CMS approval, and one that has benefit reductions but because of the fast timeline, people are uncomfortable with.

Lynn Read responded the department did not have an alternative plan. They put everything they could think of on the table in building the Governor's proposed budget, trying to minimize the impact on clients and providers.

The other $170 million is focused on hospitals and managed care and the DRG payments. The only flexibility would be with some miscellaneous fee-for-service reductions, but that would not save enough money.

Senator Winters inquired if it would be possible to bring provider groups to the table to work on alternatives in order to come up with the savings and efficiencies?

Lynn Read answered she did not know if we could get there with the savings needed and that we would be proposing provider reimbursement cuts. Managed care is driven by actuarial certified rates, so there's not a lot of flexibility there.

Rick Wopat asked if the department could submit a proposal to CMS based on some of the recommendations and then move forward to not implement those recommendations. That would provide a window between now and sometime in the spring of 2006 to seek alternatives.

Lynn Read said that is an excellent suggestion. CMS, in the past, has allowed the department flexibility on not implementing a proposal we submitted and CMS approved. There is flexibility in that arena.

Rick Wopat inquired who has the ultimate decision-making authority responsibility, the Medicaid Advisory Committee or DHS.

Lynn Read responded that the Medicaid Advisory Committee is an advisory committee but that DHS has final decision-making authority. What the department is looking for today is the Committee's best thinking on the issues, their recommendations and testimony and additional ideas that are surfacing in the hearing.

Testimony – Angela Kimball

Angela Kimball, representing the Association of Community Mental Health Programs, shared concern of the community mental health programs about the health of their clients. She said while working with the legislature, one of the key things missing was information on who exactly is covered. She suggested the Committee ask and look for information that truly profiles who the client population is that's being covered. For mental health clients,

she was unable to ascertain how many are fee for service with a serious mental illness and what their average length of stay in the hospital would be. She believes that it is impossible to make rational, coherent decisions and understand the system impacts without client and provider profiles.

Testimony – Ellen Pinney

Ellen Pinney, representing Oregon Health Action Campaign, asked the Medicaid Advisory Committee (MAC) to oppose the recommendations by DHS She asked the Committee to request better numbers from DHS about the population to be impacted. She asked that DHS come back with a proposal that distributes the impact of the cuts to both managed care and fee-for-service enrollees. She said cutting by category of health care, cutting services by category violates the fundamental tenant of the OHP.

Ms. Pinney commented on two areas she sees specific problems:

- Elimination of over-the counter drugs will drive people to go to prescription drugs, at a much higher cost. This is penny wise and pound foolish.

- Elimination of graduate medical education in a time a provider shortage doesn't make sense.

Ms. Pinney recommended that the Committee aggressively seek Medicaid enrollees, both in fee for service and in managed care, from rural and urban areas, to serve as members of the Committee.

She reminded members that the income and health status of the population targeted for these fee-for-service cuts are predominantly aged, blind and disabled clients.

Ms. Pinney asked the Committee to ask DHS to reconsider the $6 million in higher reimbursement reallocation that is going back to hospitals.

Tina Kotek responded that the Committee agrees that there needs to be Medicaid consumers on the panel. They are working to complete the full membership.

Rick Wopat asked whether the issue around the cuts was one of fairness or is it the cuts that are opposed.

Ellen Pinney responded it is an equity issue. The proposals discriminate against people living in rural Oregon, who do not have a choice of managed care.

Carole Romm inquired if the 18-day hospital limitation applied to DRG hospitals.

Lynn Read answered the 18-day annual limit would apply only to DRG hospitals, which are reimbursed on basically a flat payment per DRG combination of need. If a person has a hospital admit of 5 days, then comes back at a later date and has a 15-day stay, the hospital would be paid. The hospital would not be reimbursed if the patient came in for a third visit during that year because there were no days left in the benefit.

Rick Wopat asked if the 18-day limitation would affect the outlier payment.

Lynn Read responded the outlier payment would not be affected. If the beginning of the hospital stay is under 18 days, the whole stay would be covered regardless of how many days.

Allison Knight, a manager at OMAP, gave a little background on the stakeholder meetings. The proposed actions will have a large impact on providers and clients. DHS held stakeholder meetings to tell hospital providers about the proposed benefit reductions and to get ideas on alternatives. One mentioned would be to recalculate the outlier formula to achieve the targeted savings in lieu of other cuts that might be more difficult to implement and hard on providers and clients.

Two of the proposed actions were in the Governor's proposed budget and moved through the Legislatively Adopted Budget. Those two actions were graduate medical education and the 18-day limitation on hospital days. Another action would be to have some efficiencies in using the emergency department that that would include having a nurse hotline to provide access for clients to call in and get advice. The department has developed and has been using for years unique DRG weights that reflect a higher cost for serving primarily prenatal care and some rehab services. These four actions were presented to stakeholders at the August 19th meeting. The department asked for ideas from the stakeholders on alternatives for hospital savings.

One of the ideas put forth would be to recalculate the outlier formula to achieve the targeted savings in lieu of implementing some of the other cuts. These cuts have a large impact on both our clients and providers. DHS wanted to give the stakeholders a chance to digest what the actions would mean for them and seek any ideas for alternatives to these cuts.

The department may have some flexibility around the unique DRG's and the emergency department efficiencies.

The original proposal in the Governor's Budget applied the 18-day limitation to all hospitals. In interactions with the legislators, Bryan Johnston, Director of DHS, agreed that the 18-day limitation would apply to only DRG hospitals.

Dick Stenson asked for an overview of the $170 million and how the savings would be achieved.

Allison Knight responded the following areas of savings:
$10 million from miscellaneous unidentified fee-for-service costs, including non-emergent medical transportation
$ 5 million unidentified in terms
$ 12 million from cost-of-living adjustments for physicians
$ 9 million from graduate medical education
$ 2 million from miscellaneous
$132 million from reducing capitation rates to managed care plans so they would only have enough money built into their capitation rates to reimburse hospitals at 72% of cost instead of $100%.

Tina Kotek found it troubling that the Hospital Association did not have numbers so they could determine the impact to their providers and hospitals. The governor must have had calculations in order to propose actions in his budget. She asked the department to share that information if they had it.

Allison Knight indicated that DHS did share the pricing at the stakeholder meetings but that was an aggregate. The department has received requests for data to be broken down by provider, by client group, by region. This data exists but it will take some time to pull and verify.

Lynn Read added that for some of the actions the DHS' budget group will use an actuary for the pricing, done at the level for budget purposes. This

isn't the level that would actually help the stakeholders in their policy decision-making.

Tina Kotek stressed that the stakeholders need to best numbers possible. She asked if DHS has concerns with new options being put on the table and how do they intend to incorporate those?

Lynn Read responded that the public hearing today is truly an opportunity in terms of influencing and informing the decision-making process. She reminded committee members that DHS is on a very short timeline. Ms. Read indicated that the department needs to balance moving forward with a waiver amendment with additional actions that might be a substitute.

Rick Wopat asked if not putting back the $132 million in hospital reimbursement only affected DRG hospitals, assuming that DHS is statutorily required to reimburse Type A and B hospitals at 100% of cost. He also asked what percent of the $150 million reimbursement to DRG hospitals this actually comprises. Are there unintended consequences to targeted hospitals? Do you see DRG hospitals dropping out of Medicaid?

Allison Knight said she did not have that information with her but would provide it. {Sue – please remind Lynn and Allison that we should provide this information at the Nov. 3 meeting.}

Lynn Read commented that she has not heard any indications of DRG hospitals that will not serve Medicaid clients.

Rick Wopat inquired by limiting CPI increases for fee-for-service physicians, given the rising cost of health care, are we actually limiting that ability for access?

Lynn Read said as we fall farther and farther behind in our payment fee schedule to fee-for-service providers to provide care for our clients, it will absolutely have an impact on access and provider participation.

Rick Wopat asked what happened to the Administrative Service Organization (ASO) proposal for areas of the state that did not have managed care.

Lynn Read said the department is finalizing a strategic plan to the delivery system to expand fully-capitated managed care plans into counties that don't have any. The second choice would to be to move partially-capitated health plans. The ASO would be the third choice. A lot of analysis was done related to the ASO but it was set aside while the department moved forward with directives from the 2003 legislative session.

Carole Romm asked what the impact is on emergency department use with the lack of cost-of-living increases for fee-for-service providers.

Lynn Read responded clearly there is an impact. If there were more physicians serving OHP clients in the fee-for-service delivery system, and willing to do so because of adequate reimbursement, there wouldn't be as much emergency department use.

Elizabeth Byers asked why the department has to use the OHP to balance their budget.

Lynn Read said there have also been significant reductions elsewhere in the department, i.e., long term care. The department has to look at the need, what the charge is and where there is some flexibility in order to make the reductions. Decisions are made at a departmental level that cross over all DHS programs.

Jim Russell asked Lynn Read what her estimation was of the hospitals revisiting the provider tax.

Lynn Read did not know whether there would be broad-based interest in the hospitals for supporting an increase in provider taxes. Dialogue would begin with the hospitals.

Rick Wopat indicated, in his opinion, raising the provider tax would not be acceptable. We need to seek new ideas rather than resurfacing old ones.

Dick Stenson asked if the department had considered raising the $15 million or an across-the-board percentage reimbursement cut for all programs rather than targeting specific programs.

Lynn Read said it was a consideration for there are reasons the across-the-board percentage cut could not be done. In managed care, the rates are

governed by actuarially-determined rates that are certified by the actuary and approved by CMS according to strict criteria. Managed care reimbursement is approximately 65% of the total OHP budget. Certain other programs have state plans that are filed with the federal government and describe exactly what our reimbursement methodology is. In order to make a change, DHS would have to seek approval from the federal government. The department has more flexibility in determining physician reimbursement.

Tina Kotek asked the committee for an informal agreement that staff would go back and put together something in writing on the recommendations proposed today. The list of recommendations would be sent by e-mail to the committee for their review.

Special Appropriations

Bob DiPrete explained that Senate Bill 5576 A-Engrossed instructed state agencies to explore the possibility to obtain flexibility from the federal government to use the $4 million, currently in a special appropriations fund in the FHIAP's budget to increase coverage through the Children's Health Insurance Program (CHIP) and/or OHP Standard. Mr. DiPrete asked the Committee for ideas about how this might be done while both meeting the state's policy objectives and winning CMS approval. He mentioned a few ideas that had surfaced in preliminary discussions:

- Provide 12 months eligibility instead of 6 months for CHIP children
- Expand eligibility for children up to 200% of federal poverty
- Eliminate the asset test for children

Bob DiPrete also noted that the decision will rest with the Emergency Board on whether all or part of the $4 million is to be reallocated from the FHIAP budget to increase expenditures in OHP Standard or CHIP in order to meet the Maintenance of Effort requirements.

Carole Romm asked if CHIP was preferred over OHP Standard.

Lynn Read answered the legislature took the $4 million that it intended to put in the Insurance Pool Governing Board's (IPGB) budget and placed it instead in a Special Purpose Appropriations fund. This would allow them to make a decision prior to June of 2006 on where to spend the money. If no decision is made, the money would automatically go back to the IPGB budget. CMS has indicated Maintenance of Effort means the money would

be spent on an expansion population. Using the money to expand OHP Standard might be a hard sell with CMS because they approved Oregon's demonstration where we had a program for OHP Standard and then watched it scaled back from over 100,000 people to 25,000 enrollees.

IPGB plans to submit a letter to the Emergency Board that will be a placeholder of where we are in the process. The policy decision-making rests with the Emergency Board. If the Emergency Board decides the money can be moved, DHS would the seek approval from CMS.

Rick Wopat asked Lynn Read to expand on the concept that CMS might not be willing to approve expansion of OHP Standard.

Lynn Read explained the Maintenance of Effort concept relates to bringing in federal match for the FHIAP program which was a state-operated program. In order for the federal government to agree, the state had to put $8 million in the program each year for 5 years. Due to Oregon's budget shortfalls, they are now in a catch-up phase because they were unable to put the $8 million into that program every year.

Ellen Pinney – Testimony

Ellen Pinney explained that while the budget for the Oregon Health Plan (OHP) was going to increase by 7% over the next biennium, forcing the department to make reductions, the Family Health Assistance Program's (FHIAP) budget was scheduled to increase 71%. This is due to the Maintenance of Effort requirements. The Maintenance of Effort money should be targeted for what it was originally intended. FHIAP was never intended to be a replacement for OHP Standard. The legislators agreed to this process due to their concern that FHIAP was using CHIP money for adults. CMS has also started to be cautionary to states that use CHIP money for adults as opposed to kids because CHIP money was originally intended for children.

Doug Riggs – Testimony

Doug Riggs, representing the Oregon Primary Care Association (OPCA), stated the Government Accountability Office (GAO) has actually raised concerns about states that use money from this program for coverage of adults with no children. By moving the $4 million would not be taking

away from the FHIAP program, it would be reducing the rate of increase for FHIAP. The money would be set aside for potential use in other beneficial programs which could have more of an impact on especially kids' health care.

Mr. Riggs agreed with the four proposals for using the $4 million in the Special Purpose Appropriation fund:

- Remove the requirement that children be uninsured for six months prior to being eligible for OHP or FHIAP
- Remove the eligibility asset test for children, currently set at $10,000
- Expand coverage for CHIP to children under 200% of federal poverty
- Provide one year continuous eligibility for CHIP children

Mr. Riggs concluded that the above four recommendations were OPCA's top priorities. He said both DHS and the stakeholder groups are currently working to decide what would be the most appropriate recommendations to CMS, ones they might be more willing or interested in accepting.

Ellen Pinney added to her earlier testimony that the Oregon Health Action Campaign (OHAC) believes that public health care dollars, which fund the OHP and FHIAP, should go to those that are the most medically and economically vulnerable. In this case, she believes the expansion of the $4 million should be targeted at OHP Standard.

Ms. Pinney proposed targeting the money to expand coverage to adults who have children. One of the reasons for this proposal is that if a parent doesn't have health insurance, it is less likely that the child, even if he does have insurance, will receive care. The major reason children don't enroll is that their parents are not covered.

Carole Romm asked Doug Riggs how OPCA arrived at the endorsement of the money to go to CHIP instead of OHP Standard.

Doug Riggs explained there are two reasons. Allocating money for Children's Health Insurance programs (CHIP) would bring in federal matching dollars. Secondly, 13,000 children could be covered with the federal match under CHIP versus 2,300 with the same amount of money through OHP Standard.

Ellen Pinney stated her belief that the federal government would be more amenable to using CHIP dollars for adults who have children. Currently, Oregon is using CHIP funding for FHIAP adults regardless of whether they have children or not.

Elizabeth Byers inquired if a policy package could be submitted using $1 million for CHIP outreach and $3 million to expand coverage to adults with children.

Lynn Read responded that the department can submit any type of policy package but we will need to submit a package we can track for CMS.

Tina Kotek asked the Committee if they had to prioritize, is there particular proposals that they thought more important than others.

Elizabeth Byers said she supports expanding OHP Standard for adults with children, removing the six-month enrollment requirement, and third, the one-year continuous eligibility.

Tina Kotek expressed concern about parents losing health care, and if the department could get CMS approval, she would like the money targeted to parents in OHP Standard. She added that she believes the six-month uninsurance period would probably be the most sellable to CMS in terms of expansion.

Carole Romm would support OHP Standard enhancement as her first priority as she has seen the impact on the well being on people and social services throughout the state. Her other priorities would be coverage for children under 200% of federal poverty and one-year continuous eligibility.

Rick Wopat also supported enhancing OHP Standard. He did comment that removing the six-month period of uninsurance and one-year continuous eligibility would not be adding an additional group of population to the OHP.

Dick Stenson agreed with Dr. Wopat’s priorities.

Jim Russell supported enhancing OHP Standard, prioritizing people, at the lowest income range, who have lost OHP coverage. His second and third

priorities would be removing the six-month waiting period and adding the one-year of continuous eligibility for children.

Carole Romm indicated that Committee members seem to all be in agreement to expand OHP Standard and asked if there should be some prioritization within that such as chronic conditions, mental health, or level of federal poverty.

Lynn Read said that Bruce Goldberg could speak more eloquently to the barriers to focusing eligibility on medical conditions, but reminded the Committee that the department is on a very short timeline to submit the proposal to CMS.

Jim Russell asked if parents could be targeted for the $4 million Special Purpose Appropriation fund.

Lynn Read said there certainly is an opportunity there to target those at the lowest income level, 10% of federal poverty. The department is currently not set up to do that, but she believes CMS could have an interest in doing that.

Ellen Pinney sees two hurdles for the department. First is the Emergency Board which has to decide where the money should best be put. Would they agree that it should include OHP Standard? Second, how would they look at income, condition or parental unit?

Benefit Reductions

Bob DiPrete agreed to develop a draft of the MAC recommendations for approval by the Committee through email.

Rick Wopat recommended that the department move forward in their proposal to CMS with the worst-case scenario, the recommendations proposed today, and then work with the parties involved to find alternatives around some of these cuts.

Carole Romm suggested using the list of recommendations that the Committee developed in May.

Rick Wopat agreed that dental and vision cuts would be the least offensive.

Elimination of over-the-counter drugs and the fee-for-service issues around hospitals would be the next priority. The Committee would prioritize graduate medical education and CPI increases for physicians as high-priority issues. Discussion needs to happen soon on alternatives for cutting the two top priorities.

Lynn Read added providers are to receive a CPI increase in October of this year, and an increase in October 2006. The current plan is not to have an increase for the two-year period.

Allison Knight indicated that graduate medical education is included in the January 2006 capitation rates as well, and we would have to have a recalculation of those rates. Contracts would need to be changed for a July 2006 implementation.

Carole Romm felt comfortable with the reductions in over-the-counter drugs, using the criteria, with what is being cut. She suggested that the Committee find out how much money would be saved with the alternatives proposed by the dental community.

Lynn Read responded that the department would be talking with the dental community about the dental reductions alternatives.

Tina Kotek asked about limitation of services versus elimination of dental services?

Lynn Read said the dental care organizations are suggesting probably a combination. DHS would have to evaluate whether a limitation of each service would require CMS approval or whether it could be implemented by administrative rule. The department will have dialogue with the dental community. The dental proposal recommended alternatives to replace other cuts.

Cedric Hayden recommended that adult dental not be completely eliminated. Deborah Cateora, from OMAP, has been working with the dental care organizations to reach the $1.7 million General Fund reduction in dental.

Elizabeth Byers expressed concern that people who are on Social Security, due to a vision issue, would not receive care for their disability and that this would deteriorate their quality of life.

Allison Knight indicated even though vision exams and glasses would not be covered, the department looked at Medicare's coverage policy, and if there is a medical condition to justify coverage, exams and glasses would be covered.

Rick Wopat suggested challenging the optometrists and ophthalmologists to provide care for those who have lost coverage as other health care providers have done, e.g., free clinics, medication-assistance programs.

Tina Kotek shared concern that she was uncomfortable eliminating vision completely for the OHP Plus population and reluctant to say we'll figure how the private sector will pick this up. She believes it would set a bad precedent.

Bruce Bishop, representing the Hospital Association, said that he didn't believe that advocacy for the restoration of the vision benefit would go very far because the legislature made a clear-cut decision for the reduction in House Bill 5576. Lynn Read agreed with that assessment.

Elizabeth Byers asked if the vision exam could be a medical exam. Then the person would have a prescription to purchase the glasses.

Rick Wopat expressed concern that eliminating over-the-counter drugs would drive patients, seeking aspirin, to the more expensive prescription medication.

Carole Romm was uncomfortable with three areas of the benefit reduction proposals having to do with providers.

- CPI increase – physicians haven't had an increase for 8 years
- 18-day hospital limitation
- Graduate medical education

People speaking on behalf of the hospitals were angry about how the process had taken place. Ms. Romm stressed that more work needs to be done before these reductions are proposed to CMS.

Allison Knight indicated that there was a desire with the stakeholders and DHS to look at other alternatives. DHS would still have to seek advice from the Department of Justice as well as far as being able to substitute those

actions that were specified in the budget. DHS will continue to work with the stakeholders to craft something.

Lynn Read thought it was unlikely that that process would generate the benefit reduction that we have to submit to CMS within the 60 days, but there may be something else that would not require CMS approval. The base DRG would require CMS involvement but does not fall under House Bill 3108's 60-day waiver submittal timeline.

Rick Wopat indicated that DHS hasn't really explored the fairness, the equity issue, of spreading the reductions across the broader population and just focusing on the fee-for-service population.

Lynn Read responded the fee-for-service reductions apply to the hospital 18-day annual limitation but not to dental vision or over-the-counter drugs. There is a trade-off because managed care plans can actually manage the benefit whereas the state is prohibited by law from doing that.

Rick Wopat asked if there are any other Type A DRG hospitals impacted by the 18-day hospital limit reduction besides those in Lincoln and Jackson counties.

Lynn Read responded there are a lot of people who are not in managed care and have high medical needs that would be going to Oregon Health Sciences University (OHSU) either by virtue of where they live or that they're being transferred in for that tertiary care. Approximately 25% of OHP clients are fee-for-service. Many are also Medicare clients who would not be impacted by this reduction. Baker County does not have managed care but its hospital is not a DRG hospital.

Rick Wopat expressed concern about the legality of the 18-day hospital limitation because the reduction differentiates, not based on where the client lives or what his disease is, but whether or not he is in managed care or not in managed care.

Dick Stenson recommended that the department not go forward with the waiver, but to bring the providers and advocates back to the table and ask them, what's a better idea?

Lynn Read stated the department is required to submit the $15 million reduction package to CMS. They feel compelled because they're not sure where else they will find the savings. The department could leave the 18-day hospital limit off the list completely and go back to their partners and say "Help us."

Bob DiPrete asked what the consequences are of not asking for a waiver from CMS on the 18-day hospital limitation if the department is unable to develop an alternative way of saving those dollars identified by the Emergency Board. What position would that put DHS in?

Lynn Read responded that it would mean the Department had a budget that was out of balance. The department would have to come back to the Emergency Board and report they are out of balance by whatever the amount was in the General Fund. The budget is currently extremely tight with no surplus. Additional management actions would have to be taken. From the discussion at the hearing today, it is the intent that DHS will identify those working with the hospitals to get something in place that will be an effective management action up front.

Bob DiPrete was asked to summarize the Committee's recommendations on the benefit reductions proposals discussed at today's meeting and send a draft letter to the Committee for review and approval.

Meeting adjourned.

MEDICAID ADVISORY COMMITTEE
July 19, 2005
Minutes

Present: Bruce Bliatout, Michael Garland, Tina Kotek, Carole Romm, Jim Russell, Carmen Urbina

Absent: Elizabeth Byers, Donna Crawford, Rosemari Davis, Kelley Kaiser, Yves Lefranc, MD, Dick Stenson, Rick Wopat, MD

OHPR: Bruce Goldberg, MD, Bob DiPrete, Darren Coffman, Gretchen Morley

OMAP: Lynn Read, Mary Reitan, Candy Broucek

TOPIC	DISCUSSION	ACTION
Introductions and Welcome **Approval of minutes**	Bob DiPrete opened the meeting in the absence of chair, Kelley Kaiser. Jim Russell and Carmen Urbina were introduced as new Committee members.	Information item
Objectives of Meeting	Bob DiPrete reviewed agenda items to be discussed at this meeting.	Information item
State and Federal Medicaid Advisory Committee Requirements	Copies of the Federal requirements (21,011.12, 42 CFR 431.12) and the State Oregon Revised Statutes (Chapter 414.211-227) were given to members to help them become more familiar with the purpose of the Committee.	Information item
Advisory Boards/Roles	***Health Policy Commission*** Gretchen Morley, Executive Director, of the Health Policy	Information item

Advisory Boards/Roles	Commission (HPC), explained that the Commission was created as the result of passage of a bill in the 2003 legislative session. The HPC replaced the Health Policy Council, and consists of 10 members, appointed by the Governor, representing a broad spectrum of perspectives on health and 4 non-voting legislative members: • Rep. Billy Dalto • Rep. Mitch Greenlick • Sen. Ben Westlund • Sen. Richard Devlin Members serve three-year terms. The legislative mandate for the Commission is to focus on health care costs and access to care. Work groups were formed to concentrate on: • Quality/transparency issues working on hospital measures. • Delivery Systems model. The work group has been working with local counties across the state to develop a model to improve access to health care. This group has also been working with Susan Allan, the new Public Health Administrator, on the public health effort to create goals for the state in health care delivery. • Costs The Commission is working to pull group efforts together to build an agenda of short and long-term goals between the state and local communities prior to the next legislative session.	Information item

Advisory Boards/Roles	***Health Services Commission*** Darren Coffman, Executive Director for the Health Services Commission (HSC), presented a brief history of the Commission. The HSC was created in 1989 resulting from the passage of Senate Bill 27 with the charge to prioritize health services for the Oregon Health Plan (OHP) from the most important to the least important. The Commission consists of 11 volunteer members, including 5 physicians, a public health nurse and a doctor of Osteopathy. Members serve 4-year terms. Eric Walsh, MD, from Oregon Health Sciences University, chairs the HSC. The first Prioritized List of Health Services was created in February 1994. The Oregon Health Plan Demonstration received final approval from the Health Care Financing Administration on March 19, 1993. 47 public meetings were held around the state to solicit public values on what services should be valued high and low on the list. For example, the public valued preventive health services, maternity and early intervention as high and infertility as less important. The Prioritized List consists of 730 line items. The HSC ranks health services and then submits the Prioritized List to an actuary for pricing. The Prioritized List and its pricing are then presented to the legislature for decisions on funding level. Every two years the Prioritized List of Health Services is reviewed by the Health Services Commission (HSC) for changes in service rankings or pricing. Centers for Medicare and Medicaid Services	Information item

Advisory Boards/Roles	(CMS) must approve changes to the funding level. CMS has not accepted all legislatively approved changes to the funding level. When a 30-line reduction was requested in 2003, CMS only approved a 3-line reduction at Line 546. The Commission is now focusing on the makeup of line items, using the latest evidence-based research to update which services are more effective or less effective than others. Governor Kitzhaber asked the Commission to develop a second prioritized list with a reduced benefit package for the OHP expansion eligible population or "non-categoricals". The Commission and the Health Council held community public forums to define what optional services were more important and to propose cost sharing. The reduced benefit package, OHP Standard, was created by overlaying the more detailed prioritized list of CT pairs with prioritized general categories of services. The Waiver Application Steering Committee was formed to help design the OHP Standard program. The Committee used the benefit priorities of the Commission with different cost sharing models to develop the OHP Standard benefit package. Rick Wopat, MD, at the last HSC meeting, proposed a new way to look at OHP benefits, focusing on prevention and disease management which may help to expand coverage. The Commission has assigned a work group to look at this concept. Michael Garland extended thanks to Darren Coffman for his	Information item

Advisory Boards/Roles	dedication and commitment with the Commission. Health Services Commission's recommendations on the prioritized list are submitted for approval to the Governor and legislature every two years. Upon approval from the Centers for Medicare and Medicaid Services, the Department of Human Services (DHS) will implement the benefit package. Lynn Read indicated that the Office of Medical Assistance Programs (OMAP) evaluates what is the equivalent of where the line on the prioritized list is drawn in order to build their budget request package for the Governor's Recommended Budget. Bob DiPrete also expressed his appreciation for the work of the Health Services Commission (HSC). The HSC started out with no blueprint for how to rank services in order to build the prioritized list, and were under intense scrutiny from the federal government, legislature, advocates, and stakeholders. The Commission also showed that it is possible to integrate mental health and chemical dependency services with physical health services, and with dental services.	Information item

Other Committees	***Health Resources Commission (HRC)*** – encourages the appropriate use of medical technology by informing and influencing health care decision makers through its analysis and dissemination of information concerning the effectiveness and cost of medical technologies and their impact on the health and health care of Oregonians. ***Safety Net Advisory Council*** ***Oregon Health Plan Contractors*** ***Task Force on Racial/Ethnic Disparities*** was disbanded two years ago. The Medicaid Advisory Committee (MAC) will be looking at issues relating to health disparities across racial and ethnic communities. Carmen Urbina requested that an organizational chart of how the committees/groups connect with one another be sent to members. Tina Kotek requested a copy of the final report from the Racial/Ethnic Task Force be sent to Committee members.	An organization chart of how the committees/ groups connect with one another be provided to members. A copy of the final report from the Racial/Ethnic Task Force will be provided to Committee members.
An Overview of Medicaid in Oregon	Lynn Read presented an overview on the 2005 Ways and Means Budget Presentation. Two-thirds of the budget for the Department of Human Services (DHS) funds Medicaid programs: ***Seniors and People with Disabilities (SPD)*** – determines eligibility for Medicaid seniors and people with disabilities and administers the long-term care program (nursing facilities; assisted living, foster homes).	Information item

An Overview of Medicaid in Oregon	***Children, Adults and Families (CAF)***- determines Medicaid eligibility for children, families, expansion Oregon Health Plan adults, Temporary Assistance for Needy Families (TANF), and also determines eligibility and administers programs child welfare, food stamps and targeted case management services. ***Health Services (HS) –*** • *Public Health* – Susan Allan, new administrator Family planning expansion for clients with incomes under 185% of federal poverty (more than 100,000 clients) • *Mental Health and Addiction Services* – behavioral health and mental health institutions • *Office of Medical Assistance Programs* – acute medicine component of the Oregon Health Plan Serves as focal point for Centers for Medicare and Medicaid Services (CMS) Lynn Read explained she is serving as Interim State Medicaid Director while DHS is in transition, currently waiting for a new Director to be appointed. OMAP administers: • OHP Medicaid • OHP Children's Health Insurance Program (CHIP) • non OHP Medicaid programs that receive Medicaid dollars but are not part of the OHP	Information item

An Overview of Medicaid in Oregon	Prior to implementation of the OHP, the Office of Medical Assistance Programs operated a traditional Medicaid program under Title XIX of the Social Security Act. Federal regulations mandate coverage for certain categories of clients and some services. Medicaid coverage must be statewide with freedom of choice for clients to choose providers with no discrimination for coverage and payments to guarantee clients access to care. Oregon applied for the OHP Demonstration Waiver and received approval from CMS in March 1993. The OHP has been constantly evolving since implementation in February1994. Currently, for every dollar Oregon spends on Medicaid, about 62 cents is from federal funds. The Family Health Insurance Assistance Program (FHIAP) now also receives federal match under the OHP. Lynn Read explained the achievements since implementation of the OHP to Committee members in their 2005 Ways and Means Presentation handout. Populations covered under the OHP include: • Pregnant women with incomes below 185% federal poverty • Children under age 19 years with incomes below 185% federal poverty • Foster children with incomes below 49% federal poverty • Temporary Assistance to Needy Families (TANF) with incomes below 49% federal poverty	Information item

An Overview of Medicaid in Oregon	• Aged/blind/disabled – must cover to Supplemental Security Income (SSI) levels. Oregon covers up to 300% of SSI (about 225% of federal poverty. Many in this population are dual eligibles (Medicare/Medicaid), and their drug benefit will change in January 2006, with implementation of the Medicare Modernization Act – Part D. Ballot Measure 30 removed General Funds and closed enrollment in July 2004 at 55,000 enrollees in the OHP Standard expansion population. Provider taxes from managed care plans and hospitals now support about 29,000 clients. OHP Standard caseload will need to attrition down to approximately 24,000 in order for funding to be sustainable through the rest of the biennium. Family Health Insurance Assistance Program (FHIAP) provides a subsidy for about 15,000 Oregonians with incomes under 185% of federal poverty in both group and individual coverage. The state had to agree to a Maintenance of Effort (MOE) with CMS to spend $8 million a year for 5 years to operate the FHIAP program. The legislature is currently considering moving some of the MOE dollars to the public Oregon Health Plan and will need CMS agreement in order to move the money. The General Assistance program will again be eliminated during this legislative session. DHS also provides coverage for non-OHP groups: • Breast and cervical cancer – about 200 clients with incomes below 250% of federal poverty	Information item

An Overview of Medicaid in Oregon	• Medicare Part B premiums for approximately 70,000 clients 20,000 – premiums and for some, deductibles and co-insurance 50,000 – full wrap-around coverage • Prescription drug coverage is provided for HIV and transplant clients who were participating in the Medically Needy program when it ended on January 31, 2003. Lynn Read described benefits covered in the 2004 benefit package for both the OHP Plus and OHP Standard population. The following benefits are limited for OHP Standard: • Dental – limited to emergency only • Hospital care – limited benefit • Vision – eye disease treatment only • Home health – no coverage • Medical equipment and supplies – limited benefit • Medical transportation – emergency only The Citizen/Alien-Waived Emergency Medical program (CAWEM) provides a limited benefit (emergent care/delivery) for clients who qualify otherwise for medical assistance except for citizenship. The biennial budget of $30-$40 million per year is spent mostly on delivery. Prenatal care is not covered. The child will qualify as a citizen when born. Lynn Read explained the OHP managed care delivery system:	Information item

An Overview of Medicaid in Oregon	Fully Capitated Health Plans (FCHPs) – 13 managed care plans provide physical health and chemical dependency services for 74% of OHP clients. Physician Care Organization (PCO) – Kaiser is the only PCO providing physical medicine services, but not inpatient hospital. Primary Care Manager (PCM) – serve areas where there is no FCHP and provide primary care, monitor continuity of care, initiate referrals for consultations and specialist care. Dental Care Organizations (DCOs) – provide a dental benefit for approximately 90% of OHP clients. Mental Health Organizations (MHOs) provide a full range of mental health benefits to approximately 88% of OHP enrollees. Lynn Read indicated that OMAP is responsible for a DHS performance measure: ***The reduction of health disparities as measured by the proportion of OHP clients who receive primary health care services annually broken out by racial/ethnic categories.*** OMAP is working with community groups and managed care plans to target racial/ethnic health disparities, particularly in the areas of diabetes and asthma. The significant project for this year will be enrolling 50,000 Medicaid/OHP dual eligible clients into Medicare Part D for the January 1, 2006, prescription drug benefit.	Information item

An Overview of Medicaid in Oregon	The contract for the new Medicaid Management Information System (MMIS) has been awarded to EDS. President Bush has proposed National Medicaid Reform with a savings of $10 billion from states over the next 5 years. A new federal Medicaid Commission has been formed to study recommendations. Nancy Atkins, chair of the State Medicaid Directors, serves as a member and will be a voice for the states. Department of Human Services' budget has not yet passed through the legislature. An unknown is what will happen to adult dental? Lynn Read views the Medicaid Advisory Committee as a valuable forum to solicit public input and present a diverse range of views. Bruce Bliatout inquired how many of the Committee's recommendations have actually been incorporated. Lynn Read responded the elimination of premiums for OHP Standard clients with incomes below 10% of federal poverty was moved forward to the November Emergency Board who deferred action. Senate Bill 782 is now being heard which would eliminate premiums for those with incomes below 10% of federal poverty. If Senate Bill 782 passes, the loss of premium revenue will mean fewer OHP Standard clients can be served (approximately 300). Bruce Bliatout reminded members that funding for interpretation services was not considered due to other priorities. Lynn Read explained it was due to the high cost of services competing with other priorities.	Information item

Principles and Social Values	Michael Garland suggested the Committee should again solicit community input around what Oregonians value in health care and the relative strength of those values. Well-designed questions will need to be put forth on what the public values most and less in health care. The best thinking on shaping policy to reflect public values must be done deliberately and with intent. Michael Garland gave a brief overview of the 2004 Health Values Survey, a random sample survey of quantitative data. Community meetings served as the focus group method. A qualitative research group surveyed the groups. Public meetings on health care have received a lot of participation, because Oregonians have come to believe that what they say will be reflected in the programs that serve them.	Information item
OHP Context and Long Range Issues	Bruce Goldberg noted the need for exploring the effects of recent changes and long-range issues around the OHP for the OHP Waiver Demonstration renewal request that Oregon will submit in October 2006. Planning for amending the waiver renewal will begin in the fall of 2005 on how the waiver should be changed, reflecting experience with the OHP. Tina Kotek asked which waiver. Lynn Read responded the waivers granted to operate the OHP Demonstration, implemented in 1994, commonly referred to as the Waiver.	Information item

OHP Context and Long Range Issues	Michael Garland recommended the use of community focus groups to revisit defining the core services of the OHP. Bruce Goldberg said we need ask how can we make this happen given the realities we face around: • Benefits • People • Finances • Reality of state finances • Reality of how far CMS will allow us to amend the waiver. ***Benefits*** will be revisited but a long hard look will have to be taken at what would produce the best value and the best health for Oregonians. When the OHP was first implemented, medical benefits were viewed as holistic (medical, dental, vision, mental health). Given funding realities since, some benefits have been taken out. ***Eligibility:*** What is the best investment in looking at eligibility: chronically ill or chronically poor? The federal government bases priority for eligibility on poverty. A full benefit is now given to a healthy person, eligible due to poverty, yet someone with income above 100% of federal poverty, having chronic mental health problems, is not eligible to receive assistance. ***Providers, payments and access:*** Currently fee-for-service providers are being paid at pre-OHP reimbursement levels. Access to care is being lost as providers are dropping out of the program. Is it more advantageous to provide higher reimbursement to providers and serve	Information item

OHP Context and Long Range Issues	less people or make further reductions in benefits? What are the best ways to deliver care to gain the best value for the people we serve with available resources? Whatever decisions are made to Medicaid and the OHP will ultimately affect the larger state health care system. Jim Russell inquired what the Medicaid Advisory Committee's relationship to the waiver application process would be. Bruce Goldberg responded that the Committee would weigh in and provide input on ideas generated within OMAP, Office for Oregon Health Policy and Research, and the Governor's Office over the next year. The Committee will be able to seek public input and provide comment. Michael Garland suggested the Medicaid Advisory Committee, Health Policy Commission, and Health Services Commission maintain a checklist of values/principles to make sure something has not been missed. Jim Russell asked if the Committee would be genuinely involved in the process. Bruce Goldberg expressed hope of the Committee's genuine involvement to provide constructive input and comment. All stakeholders will need to move forward in a collaborative way. Lynn Read indicated DHS would move forward crafting policy packages during the summer of 2006, which could include recommendations from the Committee, to be included in DHS' Agency Request Budget in September 2006. The Agency Request Budget will then be modified and incorporated in the Governor's Recommended Budget.	Information item

Agenda for Next Meeting	Values and principles Performance monitoring Input gathering and recommendations Assistance to OMAP in operation of OHP Draft of MAC accomplishments Bob DiPrete will send Committee members a draft agenda for the next meeting on the framework of the Committee and how will the Committee implement tasks/recommendations.	Information item
Oregon Membership and Leadership	Bruce Goldberg announced that Committee membership has just about been completed. A few new members still need to be appointed. Michael Garland and Bruce Bliatout have agreed to stay on as emeritus non-voting consultants. He said that Kelley Kaiser and Rick Wopat will be leaving the Committee and asked members who would be interested in volunteering as co-chair to talk to him. Carmen Urbina stressed that it is extremely important for Committee members to attend all meetings during the next one and one-half years.	Information item
Next Meeting	The next Committee meeting will be held on Thursday, September 8, 2005, from 8:30 am to 11:00 am, in Hearing Room 50, State Capitol, 900 Court Street, NE. There will not be a meeting in August. Meeting was adjourned.	The next Committee meeting will be held on September 8.

MEDICAID ADVISORY COMMITTEE

May 9, 2005

Present: Michael Garland, Kelley Kaiser, Tina Kotek, Yves Lefranc, MD, Carole Romm, Rick Wopat, MD

Absent: Bruce Bliatout, Elizabeth Byers, Donna Crawford, Rosemari Davis

OHPR: Bruce Goldberg, MD, Bob DiPrete, Gretchen Morley, Jeanine Smith, MD

OMAP: Barney Speight, Mary Reitan

Other: Diane Lund, Oregon Health Forum

TOPIC	DISCUSSION	ACTION
Opening Remarks	Kelley Kaiser called the meeting to order. The focus of the meeting is to prioritize budget reductions.	Information item
Context	Bruce Goldberg pointed out to Committee members that currently there are three separate legislative budgets: • Governor's Recommended Budget • Senate Co-Chairs Budget • House Co-Chairs Budget Dr. Goldberg asked Committee members to prioritize the 11 investments not made in the Governor's Recommended Budget	Information item

Context	(GRB) for 2005-07. This would provide an opportunity for the Committee to share their recommendations for budget items to be restored if additional funding becomes available.	
OHP Budget Summary	Barney Speight explained to Committee members that at this time the revenue forecast is unknown. He presented data on how the OHP population, both Plus and Standard, enrollment has changed over the last three sessions: 2001-2003 2003-2005 2005-2007 **OHP Plus** 310,000 340,000 357,000 **OHP Standard** 99,000 43,000 24,000 **Priorities:** The Committee discussed the set of priorities they would recommend for restoring the Oregon Health Plan (OHP) budget items in the 2005-07 biennial budget if additional funding becomes available. The priorities were guided by the following considerations: 1. Reductions in payment to fee-for-service providers threaten the delivery of health care to all rural Oregonians. In areas where there is no managed care, fee-for-service providers are the only health care delivery system. Access to care is limited in that system due to the current reimbursement policy.	Information item

OHP Budget Summary	2. Access to care is of paramount importance. When the patient/provider connection is made, then avenues are open for the delivery of needed care. Without this connection, even the most basic, effective care is often not provided. 3. Investments in capacity for delivering care are critical in the longer run. When the training of providers is compromised, the effectiveness of health care is degraded for decades. The Committee prioritized the 11 categories of investments not made in the Governor's Recommended Budget for 2005-07 and recommends the following: ***First:*** Savings can be achieved without impairing access to care and the Committee concurs with the Governor and Legislature that the following two items should be part of the final budget: • $2.0 million reduction in non-emergent transportation. Large cities have transportation brokerages, and part of the savings will be achieved through better use of the brokerages. Clients will be encouraged to use public transport. • $4.0 million savings from fee-for-service management actions: ⇒ Adding diseases to the Disease Management Program ⇒ Prepayment review of emergency room claims ⇒ Prior authorization for certain high-cost procedures, i.e., MRI, CT scans ⇒ Utilization review of hospital claims	Information item

OHP Budget Summary	• In addition, Management of fee-for-service drugs. Unfortunately, the Legislature will not use this budget item, which would produce a $5 million savings from the effective management of fee-for-service prescription drugs, as a management action. ***Second:*** The Committee recommends the following categories be given highest priority for "buy back" if additional revenue becomes available to prevent reducing access to medically necessary care for clients. • $6.7 million in CPI increases for fee-for-service payments. This will prevent worsening access problems for clients and includes across-the-board increases for all providers. • $4.7 million to restore graduate medical education (GME) payments to help support teaching programs for health professionals. Five Oregon hospitals would receive GME payments: ⇒ Oregon Health Sciences University ⇒ Legacy ⇒ Emanuel ⇒ Providence ⇒ Merle West • $1.1 million to lift the limit on fee-for-service inpatient hospital days.	Information item

OHP Budget Summary	The Governor's Recommended Budget proposes a limit of 18 days. • $0.5 million to lift the limit on fee-for-service prescriptions • $0.4 million to cover fee-for-service over-the-counter drugs ***Third:*** The Committee recommends the next two items be given medium priority for "buy-back" if additional revenue becomes available. Reductions in vision and dental would adversely impact the general health of clients. • $12.2 million to restore adult dental services for OHP Plus clients. The Governor's Recommended Budget would continue to cover the full dental benefit for pregnant woman and children. • $2.1 million to restore adult vision services for OHP Plus clients ***Finally:*** The Committee recommends restoring the $17.3 million in the hospital capitation rate as their lowest priority. The Committee strongly recommends against any additional cuts in this budget item. The Committee believes the above recommendations are a reasonable approach to setting priorities for restoring Oregon Health Plan services and payments if additional funding becomes available. The Committee also fully supports the restoration of the $.10 per pack tax on cigarettes to restore health services for vulnerable Oregonians.	Information item

<table>
<tr><td>OHP Budget Summary</td><td>The Committee has struggled with the difficult trade-offs in other programs in their discussions in developing recommended priorities.

Rick Wopat inquired about the reductions in the Governor's Recommended Budget for Seniors and People with Disabilities' (SPD) clients:
• Elimination of General Assistance
• Elimination of coverage for the employment initiative
• Elimination of adult foster care
• Cap on enrollment under the Home and Community Based waivers

Approximately 3,000 clients would lose coverage from the elimination of General Assistance but most of them would qualify for SSI or OHP Standard.

There is legislative interest in restoring a portion or all of adult foster care.

Elimination of the employment initiative would not generate savings.</td><td>The Committee authorized by voice vote the preparation of a letter to members of the legislative committees on health care suggesting a set of priorities for restoring the Oregon Health Plan Budget items in the 2005-07 biennial budget, if funding becomes available.</td></tr>
<tr><td>Next Meeting</td><td>The next Committee meeting will be held on Tuesday, July 19, 2005, from 8:30 am to 11:30 am at the Card Room, Mission Mill Museum.

Meeting was adjourned.</td><td></td></tr>
</table>

MEDICAID ADVISORY COMMITTEE

April 20, 2005

Present: Elizabeth Byers, Donna Crawford, Rosemari Davis, Michael Garland, Kelley Kaiser, Tina Kotek, Yves Lefranc, MD, Carole Romm, Rick Wopat, MD

Absent: Bruce Bliatout

OHPR: Bruce Goldberg, MD, Bob DiPrete, Jeanene Smith, MD, Elizabeth Baxter

OMAP: Barney Speight, Mary Reitan

Guest: Matthew Breeze, MD

TOPIC	DISCUSSION	ACTION
Introductions and Welcome Approval of minutes	New members and guests were introduced. The minutes from the last Committee meeting on February 24th, were approved as written.	Information item

DHS Budget	Barney Speight updated members on the Department of Human Services' (DHS) budget process. DHS is beginning Phase II of their budget presentation to the Joint Ways and Means Human Services Subcommittee. Phase II is a high level itemization of program in the Governor's Recommended Budget. The Health Services Cluster, which includes the Office of Medical Assistance Programs (OMAP), is tentatively scheduled at the Ways and Means Subcommittee May 9-12. Public testimony will be heard May 11 and 12. The legislative Co-Chairs' budgets have been released. The major points of disagreement are in the K-12 education budget. OMAP believes a portion of adult dental for OHP Plus may be restored. Aggressive management of fee-for-service prescription drugs is expected to be added back. Most of the other reductions in the Governor's Recommended Budget will remain, including: • Elimination of vision benefits for the OHP Plus population • Reductions in reimbursement for both managed care and fee-for-service providers It is difficult for agencies to foresee what will happen as the budget pace is unusually slow this session. Both legislative houses have agreed on $12.4 billion in the General Fund. The May revenue forecast will have no effect on the legislative agreement.	Information item

DHS Budget	Michael Garland indicated the $12.4 projection came from the March forecast. The Governor's Budget proposes hospital capitation rates at 90% of cost. The Co-chairs Budget proposes to retain the 2003-05 capitation rate at 72% of cost for hospital payments through 2005-07. The OHP Standard program will continue to be financed through provider taxes. Other reductions include: • $4 million reduction in fee-for-service payments. The agency is to implement management actions to achieve this reduction. • $6 million by not implementing CPI increases for durable medical equipment and other specialty services • $2 million savings from not funding non-emergency medical transportation • $4.8 million by eliminating graduate medical education payments through the fee-for-service system • $2 million by limiting hospital days, limiting the number of prescription drugs, and elimination of over-the-counter drugs Yves Lefranc emphasized that the reductions will create a severe impact on access to health care. Currently, OHP fee-for-service patients have a four-month wait to see a physician in Portland clinics. Barney Speight responded that most of the reductions are in the fee-	Information item

DHS Budget	for-service system where access to health care already is not good. The Department is trying to enroll more clients into the managed care system. Enrollment in managed care was 77% as of March 1st. Areas where there are Fully Capitated Health Plans (FCHPs) do not have access problems. But there are problems in the rural areas that do not have FCHPs. Reductions in Graduate Medical Education will affect the following hospitals: • Oregon Health Sciences University • Providence • Legacy Good Samaritan • Legacy Emanuel • Sacred Heart • Merle West Barney Speight explained the legislative debates are still at a high level, and he does not know at this time whether there will be add-backs. Carole Romm inquired if pass-throughs are being targeted at the federal level. Barney Speight responded the feds are tightening down on inter-governmental transfers (IGTs). Oregon has an IGT with OHSU but is not currently on the federal list. Yves Lefranc indicated that Providence and OHSU residencies will be impacted by eliminating Graduate Medical Education.	Information item

DHS Update	Barney Speight explained managed care enrollment currently is at 77%. As of March 1st, enrollment in OHP Standard was 28,000 enrollees. The department expects enrollment in Standard to be down to 26,000-27,000 enrollees by July 1, which will allow DHS to stay within the fiscal budget available. OHP Standard is not supported by the General Fund, but instead by provider taxes, federal match and premiums. The provider tax will sunset in 2008. Elizabeth Byers asked if the Family Health Insurance Assistance Program (FHIAP) receives extra money from the federal government. Barney Speight responded that yes, FHIAP receives federal match. The Terms and Conditions of the OHP Demonstration Project have a 'Maintenance of Effort' (MOE) requirement which means the state must continue to fund the FHIAP program with State General Funds equal to or more than were in the program prior to this Demonstration Project. The state has not been able to find ways to renegotiate the agreement with the federal government so that MOE amount could be reduced. Tina Kotek asked what is the discussion if OHP Standard goes below 25,000 enrollees. Barney Speight said the department is exploring different options to reopen enrollment in OHP Standard. The major concern is the long-term future of the provider tax. Currently, the assessment for managed care organizations (MCO), dental care organizations (DCO) and mental health organizations (MHO) is 5.8%, and .95% is assessed on the net revenues of DRG hospitals.	Information item

DHS Update	The Bush Administration has suggested two changes in the provider tax assessment: 1. Provider tax assessment would be lowered to 3% for MCOs, DCOs and MHOs. 2. Provider tax assessment for MCO's would include all lines of business, both public and commercial. The implication for Oregon is this might cause loss of support for the tax, and there would be no provider tax assessment from managed care organizations. Rick Wopat asserted the state must consider if the provider tax ends, that the OHP Standard program will also end. Barney Speight explained to members that the contract for the first Physician Care Organization (PCO) is currently being reviewed by Centers for Medicare and Medicare Services (CMS). Kaiser Health Foundation has been awarded the contract and will serve enrollees in Multnomah, Clackamas and Washington counties. OMAP is developing a concept for the expansion of the PCO to rural counties that do not have a Fully Capitated Health Plan in their area. The hope is to expand managed care through Physician Care Organization (PCO) in early 2006 in rural areas of the state, to improve quality of care, access and cost. Barney Speight said the PCO does not include inpatient hospital services. PCO participation in the OHP Standard program will be optional. DHS would need local physician interest in a county as	Information item

DHS Update	well as an organizational infrastructure in order to establish a PCO. Jackson County and some areas on the coast have minimal FCHP participation and may be places of interest to explore for PCO implementation. Kelley Kaiser added many FCHPs may see this as an opportunity to enter the market. Kelley Kaiser asked about the creation of Administrative Service Organizations (ASOs). Barney Speight responded the Department has three priorities for 2005-07: 1. PCO Expansion 2. Replacing MMIS 3. Medicare Modernization Act (MMA) – Part D Prescription Drug which will impact 50,000 OHP "dual eligibles" on January 1, 2006. The ASO requirements in Section 10, of House Bill 3624 directed DHS to contract with FCHPs to provide administrative services in the following health services for OHP clients who receive services paid on a fee-for-service basis: 1. Prescription management of all drugs except mental health drugs. The MMA Part D will provide the prescription drug benefit for all Medicare recipients in January 2006. 51,000 OHP dual-eligible clients will receive this Medicare drug coverage and no longer will receive prescription drugs through Medicaid. Half of the dual-eligible population currently receive	Information item

DHS Update	drugs on a fee-for-service basis. The Department will have to wait until Medicare Part D is implemented before they can assess the effectiveness of an ASO for prescription drugs. 2. Administrative services management of inpatient and outpatient services. The Department would have to begin in one or two pilot areas to determine the cost savings. There are limited resources in the Department to develop an ASO capability, currently due to other high priorities (MMIS implementation, Medicare Part D, and expansion of PCOs). The Department will evaluate resources available once the high priorities are implemented. 3. Utilization of non-emergency medical transportation in areas where no brokerages are available. Currently, 25 counties have developed transportation brokerages at the community level. The Lane County brokerage will be operational in 2006. 4. Durable Medical equipment and supplies. DHS has centralized the prior authorization and fee-for-service payment in OMAP for durable medical equipment, prosthetic, orthotics, and supplies to manage costs and insure rules are applied consistently across the fee-for-service system. Transferring this function to ASOs would be probably no be cost neutral. Rosemari Davis would welcome the opportunity for her hospital in McMinnville to be included in a pilot.	Information item

Medicaid Management Information Systems (MMIS)	MMIS is a history database on eligibility as well as a claims payment system. States are mandated by the federal government to have the system. Oregon's MMIS is an antiquated system, about 30 years old, and programmed in Cobol, an outdated programming language. The new MMIS will be operational in summer-fall of 2007, and will allow more flexibility at the policy level and avoid administrative costs in systems redesign. It is a $45 million system with 90% paid by the federal government. Barney Speight said the MMIS is the most fundamental transforming technological event to hit the health care field, impacting all providers and all DHS staff. Barney Speight will ask staff from the Office of Information Systems to attend a future Committee meeting and give a presentation after the contractor is on board.	Staff from Office of Information Systems will be invited to a future meeting to give a presentation on the new MIS.

Medicaid Reform	Senator Smith's bill was adopted by the Medicaid Reform Committee in Congress. Currently, the National Governor's Association is working to engage the 50 states and the Bush Administration on how Medicaid reform should be implemented from a policy perspective. Debate continues within the federal/state partnership on how to make revisions around benefits and populations served. Rick Wopat asked if Senator Smith's bill would be heard before the Conference committee. Barney Speight responded it would be heard but the bill also establishes a committee to analyze the impact of proposed reductions from the President's FY 2006 budget and look at what Medicaid should look like in the future. Oregon **SB 824** – Elimination of Premiums for OHP Standard enrollees with incomes below 10% of federal poverty. The emergency clause is being changed. The bill is moving through the legislature on the Senate side. OMAP supports this bill from a policy perspective. The loss of revenue from the elimination of premiums for clients with incomes below 10% of federal poverty would be financed through the attrition of 300 additional OHP Standard clients leaving the program.	Information item
MMA – Medicare Modernization Act – Part D	DHS will be sending letters to the 51,000 dually eligible enrollees to enroll in a Medicare Part D drug plan. The state is trying to provide coordination between the senior organizations, physicians and hospitals to provide outreach in order to assist these clients in	Information item

MMA – Medicare Modernization Act – Part D	enrolling. Donna Crawford asked if Barney Speight would talk about choosing Part D plans. Barney Speight responded James Toews, DHS Assistant Director, Seniors and People with Disabilities, would be the appropriate person to explain this to the Committee and will invite him to attend the next meeting. Bruce Goldberg emphasized that when funding is constrained in the budget process, eligibility, benefits, and provider reimbursement will all face reductions. He suggested that the Committee could weigh and prioritize those program areas they would like to see the legislature add back if sufficient funding is available. Michael Garland recommended recovering as many clients as possible whose benefits would be eliminated as a result of cutting premiums. Kelley Kaiser suggested the Committee may be able to do the prioritization by e-mail prior to the June meeting. Yves Lefranc commented that prioritizing where to add back money will be a challenging task for the Committee. Bob DiPrete suggested the Committee have a meeting in May to discuss choices based on program reductions in the current proposed budgets. Barney Speight agreed to identify legislative reductions that may not	Barney Speight will invite James Toews, Senior and People with Disabilities, to the next meeting to talk about choosing Medicare Part D plans. A Committee meeting will be scheduled in May to discuss program reduction choices to be added back to the budget.

MMA – Medicare Modernization Act – Part D	be added back. He expressed two concerns: • Elimination of CPI will affect providers in rural areas. • Elimination of GME will have a disproportionate impact on fee-for-service providers.	Barney Speight will identify investments not made in the Governor's 2005-07 Recommended Budget
Legislative Developments	Bruce Goldberg explained that he does not know at this time if there will be additional revenue from the May revenue forecast. The legislature has been unclear on where they stand on the restoration of the cigarette tax. If the bill is passed, a decision will need to be made on where to put the additional dollars. Mental Health parity passed in the Senate, and is now in the House. The State currently covers parity for State employees. Legislative bills around transparency and hospital regulation have not been heard as yet. The biggest health policy issue is fluoridation. The bill has passed in the House and is currently in the Senate Environment Committee. Legislative bills relating to obesity are receiving lots of discussion around school health (vending machines). The focus is on children's obesity.	Information item

Legislative Developments	Elizabeth Byers inquired about the bill on Medicaid savings accounts. Barney Speight responded the bill is general in theme and not specific around the area of health savings accounts.	Information item
Planning for the Future	DHS is currently having internal discussions about the OHP waiver, which will expire in two years, and looking at ways to involve the legislature, Health Policy Commission and Medicaid Advisory Committee in the planning. Bruce Goldberg will present some ideas on the planning timeline/involvement to the Committee in June.	Bruce Goldberg will present ideas on the OHP waiver planning timeline/involvement at the June meeting.
Premium Sponsorship for OHP Standard Clients	Elizabeth Baxter has been working with the premium sponsorship group for 14 months to help clients receive medical coverage who are unable to pay their premiums. Almost $310,000 has been raised since May 2004. • 46% of the sponsorship funds were donated by Oregon hospitals to prevent disqualification of OHP clients with incomes below 10% of federal poverty statewide. Approximately 19,500 premiums have been sponsored since July 2004. • 54% of the sponsorship funds have been raised by individual counties. Approximately 7,300 premiums have been sponsored since May 2004. More than half of the funds raised covered clients above 10% of federal poverty. Challenges to sponsorship efforts:	Information item

Premium Sponsorship for OHP Standard Clients	• Data Challenge – DHS pulls the data. Eligibility data is time specific (snapshots in time). There are eligibility time constraints on the 1st of the month Medical cards. • Clients must be at risk of losing eligibility before they can be sponsored. Sponsorship is anonymous so clients don't know when or if their premium was paid. • Not all clients who need help with premium sponsorship are coded as a potential disqualification, and some fall through the cracks. • Medicaid eligibility databases do not have the flexibility to provide all the data community agencies would like to have. • Local organizations want to keep money they provide for premium sponsorship in their communities. • No lead organization has been identified to solicit sponsorship funds statewide. Elizabeth Baxter suggests the following to keep the sponsorship program sustainable: • The rule be changed so that OMAP would be responsible for the premium sponsorship program. • Data runs and reporting to sponsorship organizations occur twice monthly. • Establish a feedback loop for clients who are disqualified even though the premium was sponsored. • A communication mechanism be set up between DHS/OMAP and community sponsorship organizations regarding data and reporting.	Information item

Premium Sponsorship for OHP Standard Clients	• An alternative would be to create a client-driven model to allow the client to initiate the request to be sponsored (or use a proxy, such as Outreach organizations). A client-driven model would require: ⇒ An organizational home ⇒ Simple means of sending funds and client information to Earhart Corporation ⇒ Agreed-upon guidelines for use of sponsorship funds ⇒ Ability to sponsor premiums for multiple months at a time instead of a month-to-month basis ⇒ Donor agreement to support an infrastructure to assure monthly checks go to Earhart Corporation Elizabeth Baxter explained what they have learned from the Sponsorship Program. While eligibility data is the best means the State has now to identify OHP clients needing help to pay premiums, many are missed. Using an anonymous model for sponsorship creates confusion for clients as they do not know if their premium was paid and often get conflicting information. It is unclear how best to tap into community support without having a lead organization to take responsibility to solicit community sponsorship donations and share information. The team has found that the majority of clients with $6.00 premiums	Information item

Premium Sponsorship for OHP Standard Clients	are paying their premiums each month without sponsorship. A community sponsorship complement could be a viable model for those in the lowest income levels. Sponsorship information could be incorporated in the eligibility/recertification process. Elizabeth Baxter emphasized that without the support of DHS, OMAP and Earhart, the community sponsorship program would never have succeeded. Committed people statewide, public and private, worked together to develop the premium sponsorship concept. Data continues to show that if people have money, they will pay their premiums. Elizabeth Baxter said there is the possibility of a large non-profit organization coordinating the premium sponsorship program statewide. United Way and Ecumenical Ministries of Oregon have expressed interest. Rick Wopat inquired if the state would be willing to work with agencies such as United Way or Ecumenical Ministries. Carole Romm asked Committee members for recommendations to support a private sponsorship agency to coordinate the premium sponsorship program.	Information item

Next Meeting	The next Committee meeting is scheduled to be held on Monday, May 9, from 10:30 am to 11:30 am in Room 331, State Capitol, 900 Court Street, NE in Salem to discuss legislative reductions to the Oregon Health Plan budget that may not be added back.	
	Meeting adjourned.	

MEDICAID ADVISORY COMMITTEE
February 24, 2005

Present: Elizabeth Byers, Michael Garland, Kelley Kaiser, Yves Lefranc, MD, Carole Romm, Rick Wopat, MD

Absent: Bruce Bliatout, Donna Crawford, Rosemari Davis
OHPR: Bruce Goldberg, MD, Bob DiPrete, Elizabeth Baxter
DHS: Barney Speight, Jim Edge, Mary Reitan
Other: Carmen Urbani, Central City Concern and Tate Williams, Oregon Health Forum

TOPIC	DISCUSSION	ACTION
Introductions and Welcome Approval of minutes	Kelley Kaiser, Chair, opened the meeting. The minutes from the last Committee meeting on January 19, 2005, were approved as written. Kelley Kaiser introduced two new members to the Committee: Yves Lefranc, MD, physician with Providence S.E. Clinic in Portland Carole Romm, health care consultant Bob DiPrete noted that Tina Kotek has also been appointed but was unable to attend this meeting and will be attending the next meeting. Bob DiPrete noted for new members that the Medicaid Advisory Committee is charged with providing advice to the Governor, legislative and state officials on issues pertaining to the operation of	Information item

Introductions and Welcome Approval of minutes	the Medicaid and Children's Health Insurance Programs. The Committee also considers issues of those clients moving from the Oregon Health Plan to the Family Health Insurance Program (FHIAP) and moving the other way.	Information item
Health Values Survey	Michael Garland presented an overview of the Health Values Survey to Committee members. The Office of Oregon Health Policy and Research provided funding to Oregon Health Decisions to direct the third telephone survey soliciting public opinion on major health issues facing Oregonians. The random sample survey was conducted by Market Decisions Corporation in September 2004. Two previous surveys were held in 1996 and 2000. Survey results were then provided to the Oregon Health Policy Commission. Access to health care for all Oregonians and health care costs were the major public concerns. Survey responses also expressed: • Basic health care for all is supported • Some financial participation is expected • Cost shifting is not acceptable • Infants and small children should be given highest priority • Preventive and primary care should be guaranteed even when resources are constrained • Oregonians should be kept enrolled in health care, and the State should look at the cost and effectiveness of services provided. The public placed the highest value on cost of care in the 1996 and	Information item

Health Values Survey	2000 surveys. However, in 2004, the highest priority was placed on providing access to health care for all. Primary and preventive care were valued as high priority services in the 2004 survey. People saw preventive care as a pragmatic way to keep costs down while improving overall health care. Other values regarding the importance of health services: • Health information about one's own health is reassuring • Services that treat individuals for problems that would lead to other problems if left untreated • Services that benefit a large portion of the population • Services that save a life and show compassion for those with acute and chronic problems • Services that improve the economic productivity and social well being. Survey respondent attitudes were harsh toward people with addiction problems. The public believes in the idea of personal responsibility for one's own health. Other services (besides addiction services) receiving relatively low priority when there are limited resources: • Dental • Vision care • Mental health care • Prescription drug coverage Strong public response centered on guaranteed access to basic and routine care. In looking at policy options for the Oregon Health Plan, when resources are limited, respondents favored reducing services rather	Information item

Health Values Survey	than reducing enrollment, and supported treating conditions that may become life threatening if not treated. Respondents favored using a sliding fee scale for unemployed persons who do not have health insurance. Public programs would be used to subsidize remaining health care costs. Using the emergency room for primary care was unacceptable. Respondents felt that employers should be required to pay a portion of employed workers premiums. Public preferences centered on cost sharing and the sliding scale concept. Rick Wopat added that increased support to keep people enrolled but to drop services when resources are limited was a key component in the Oregon Health Plan (OHP) design from the late '80s on.	Information item
Oregon Health Plan	Barney Speight, Administrator, Office of Medical Assistance Programs (OMAP) explained that at the end of 2004, approximately 377,000 Oregonians were enrolled in Medicaid and the Children's Health Insurance programs (CHIP). OHP Standard enrollment was at 38,000. The Standard program has been closed to new enrollment since August 2004, and enrollment is being brought down by attrition to meet the target of 24,000 enrollees by July 1, 2005. As of February 2005, approximately 31,000 were enrolled in OHP Standard. The 2005-07 Governor's Recommended Budget (GRB) is premised	Information item

Oregon Health Plan	on Standard enrollment of 24,000, funded solely by managed care and hospital provider taxes. Total enrollment has not decreased even with the reduction in OHP Standard enrollment. The Department of Human Services (DHS) has seen a rise in the Temporary Aid to Needy Families (TANF) due to the weakness in the economy and has seen increases in some senior and foster care children's programs. Barney Speight indicated that about 50% of the clients don't re-certify for OHP Standard at the end of sixth months due to changes in eligibility over time. Rick Wopat inquired about the process for reopening the OHP Standard program. Barney Speight responded that DHS is currently looking at what approach to use for enrollment when the program is reopened. Rick Wopat asked if reducing the federal poverty income level for eligibility was still an option. Barney Speight said the department does not see a need for that now as the glidedown is on track for OHP Standard. The department would have to give Centers for Medicare and Medicaid Services (CMS) 60 days' notice in order to implement that option. DHS appeared before the Legislative Ways and Means Committee on Human Services during the last two weeks to present Phase 1 - an overview of the programs. In March, the department will go back to Ways and Means to present their proposed reductions from the	Information item

Oregon Health Plan	Governor's Recommended Budget (GRB) (Phase II). Phase III will be a work session at the end of March. Barney Speight updated Committee members on the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) - Part D. About 50,000 Medicare and Medicaid dual eligible enrollees will be moved to Medicare prescription drug plans on January 1, 2006, which will provide Medicare drug coverage. Low income Medicare beneficiaries with incomes under 150% of federal poverty may qualify for a low-income subsidy to help pay premiums and copayments. States will not receive federal match for Part D drugs provided to dual eligibles if they are for drug classes available in the Medicare prescription drug plans. Medicare Advantage Plans and Prescription Drug plans will provide the drug benefit and may use their own formularies. A major concern is that the Social Security Administration will be sending letters to 260,000 of Oregon's seniors in May, with a 6-page application form to fill out and return to Social Security to apply for the low-income subsidy. The letter gives a toll-free number to call if the individual has questions. DHS does not have adequate staff available in its field offices to help these people when they cannot reach SSA or have problems understanding the application. The federal government has not given the states any extra money to set up an information program to help these people.	Information item

Oregon Health Plan	Dr. Tina Kitchin will present Oregon's concerns and concerns from other states on the Part D program at Senator Smith's Senate Committee on Aging on March 3rd. Michael Garland inquired if there would be any savings to the states with Part D. Barney Speight responded that there would not be any savings for Medicaid and explained the federal "clawback" provision. An issue of concern is whether the prescription drug plans and Medicare Advantage Plans will have formularies that will be consistent with the patient's drug regimen. Barney noted that the MMA Part D drug benefit is the most significant Medicare policy change since that program's inception in the mid '60s. Barney Speight shared some of the potential implications to states from the President's proposed FY 2006 budget. The budget proposes: $60 billion reduction to states in Medicaid over the next 10 years. This would mean a $600 million reduction over 10 years for Oregon, or $60 million reduction per year. DHS is still in the process of analysis of the President's proposed budget. Barney Speight will share the analysis with the Committee. He believes a federal focus will be on intergovernmental transfers such as Oregon Health Sciences University and county governments which leverage federal funds. The major near-term concern is provider taxes. The FY 2006 budget	Information item

Oregon Health Plan	proposes to lower the upper limit of provider tax to 3%. Currently, Oregon's managed health care plans pay 5.7% and the hospitals pay .95% of their current revenue in provider taxes. The budget also proposes that the entire income stream of managed health care plans will be subject to the tax (commercial and public). All lines of business would be taxed. This proposal would impact Oregon's use of provider taxes to fund Medicaid. The budget proposes to tighten controls for states to receive matching dollars for administration by capping these funds. On a positive note, the FY 2006 budget proposes adding $1 billion for CHIP outreach and $10 billion to the CHIP program. States would have to come up with the matching funds. Barney Speight will send Committee members the summary of the President's proposed FY 2006 Budget. Senator Gordon Smith has sponsored a bill to establish a National Medicaid Committee to determine what the role of a federal/state partnership should look like in the future. Barney Speight will share the policy paper with the Committee. Oregon's current Oregon Health Plan (OHP) waiver will expire on October 31, 2007. At that point, we will have to renegotiate the terms of the Demonstration Project in light of the Administration's new direction. Michael Garland asked the Committee for approval of a motion to take a stand to increase policy discussion around federal changes and	Barney Speight will send members the summary of the President's proposed FY 2006 budget. Barney Speight will share the policy paper on Senator Smith's bill to establish a National Medicaid Committee.

Oregon Health Plan	the future of Medicaid from the President's proposed budget. Barney Speight asked the Committee if they would support the concept of a National Medicaid Committee as a vehicle to stimulate policy discussion at a national and state level. The Committee agreed to pend a decision on the motion until they have read Senator's Smith bill. They will vote by e-mail. Michael Garland recommended that the Committee encourage the Health Policy Commission to put Senator's Smith's bill on their next agenda for discussion.	The Committee agreed to pend their decision on the motion until they have read Senator Smith's bill.
Legislative Update	Bruce Goldberg, MD, Administrator, Office of Oregon Health Policy and Research, said there are not a lot of significant Medicaid policy changes introduced at the legislature this session, and we probably won't see significant change. The legislature will be looking for ways to fund dental and will be interested in the interface between Medicare and Medicaid on the MMA Part D drug benefit. Barney Speight indicated there are a couple of legislative bills tied to health savings accounts. HB 2644 establishes health savings accounts for Medicaid. The bill is very general and does not say how it should be implemented or what population groups it effects. Health savings accounts have different implications for different populations.	Information item

Legislative Update	Rick Wopat inquired why OMAP took the position of neutral on SB 824 and HB 2048. Barney Speight explained they were not included in the Governor's Recommended Budget. Bruce Goldberg expressed that legislators had mixed sentiment on HB 2048, restoration of the 10 cent tobacco tax. SB 501 - SB 505 are cost containment bills and expected to have significant discussion at the legislature.	Information item
Premium Sponsorship	Due to time constraints, Premium Sponsorship will be added to next meeting's agenda. Elizabeth Baxter, Oregon Health Policy and Research, provided a short overview to members. Premium sponsorship was first created in Multnomah County by two groups: Multnomah County clinics Central City Concern During 2003, OMAP and the sponsors were sharing client information in order to identify clients at risk for being disqualified from OHP Standard. However, the process was identified as a possible violation of federal "anti-kickback" statutes because the premiums were being paid by Medicaid providers for their patients. The process was changed so that no client identifiable information was exchanged. Premiums have been paid for all clients, with incomes between 0-10% of federal poverty, through the sponsorship program to prevent disqualification. Donors forward money to a third party sponsorship	Information item

Premium Sponsorship	organization, Union Gospel Mission, who, in turn, sends payment to William Earhart, Inc. for processing. Some counties have established a process where premium payments are sent to the sponsorship organization, Oregon Health Access Project, for clients in their counties, with incomes below 10% of federal poverty, who are at risk of being disqualified. The premium model is anonymous, and there is concern that there is no way to track which clients are receiving premium sponsorships. Clients have been notified that they will be disqualified if their premium is not paid by the 25th of the month. When they receive a Medicaid card on the 1st, they do not realize their premium has been paid through sponsorship.	Elizabeth Baxter will attend the next meeting to present an update on premium sponsorship.
Next Meeting	The next meeting will be held on Wednesday, April 20, 2005, from 9:00 am to 11:30 am, in Room 167A, State Capitol, 900 Court Street, NE, in Salem.	

MEDICAID ADVISORY COMMITTEE

January 19, 2005

Present: Elizabeth Byers, Rosemari Davis, Michael Garland, Kelley Kaiser, Rick Wopat, MD
Absent: Bruce Bliatout, Donna Crawford

OHPR: Bruce Goldberg, MD, Bob DiPrete
OMAP: Barney Speight, Thomas Turek, MD, Mary Reitan

TOPIC	DISCUSSION	ACTION
Opening Remarks Approval of minutes	Kelley Kaiser, Chair, called the meeting to order. Minutes from the last Committee meeting on October 19, 2004, were accepted as written.	Information item
OHPR Administrator's Report	Bruce Goldberg, MD, Administrator, Office of Oregon Health Policy and Research (OHPR) reported on: • Oregon Population Survey: Uninsurance • Medicaid Advisory Committee membership • Oregon Health Policy Commission (OHPC) ***Oregon Population Survey: Uninsurance*** The Oregon Progress Board surveys the population every two years for insurance status. The survey was completed in August and September. The Office of Oregon Health Policy and Research further analyzed the results, and found the following:	Information item

OHPR Administrator's Report	• Percentage of Oregonians without health insurance increased from 14% in 2000 to 17% in 2004. 609,000 Oregonians have no health insurance. • Percentage of children without health insurance now at 12.3%. (106,000) • 18% of employed individuals indicated they had no health insurance. • 8.8% of insured employed individuals indicated that were uninsured at some point during the year. Michael Garland: Is the 18% an understatement of people who lack health insurance, either because of the way the question was asked or because of the survey methodology? Bruce Goldberg said he would find out and bring back to the Committee. Bruce Goldberg identified several major health insurance issues: • Difficult for individuals, employers and state to afford. • High unemployment • Workers share substantially in cost of premium increases, making it increasingly difficult for them to afford to take-up or continue coverage • Cost of health care rising faster at 10%-12% per year compared to workers' incomes at 2% per year • Family income now lower than in 2002	Information item

OHPR Administrator's Report	Rick Wopat asked what is the effect on people's health status and the ability of health systems to function. He sees the increase of uncompensated care as in effect forcing providers to turn people away. Bruce Goldberg responded that the real issue is the consequences to people who do not have access to effective health care. An example, diabetics are more likely to be hospitalized. Nationally, 18,000 deaths are attributed to people not having health insurance. The growing numbers of uninsured are creating access problems and are forcing safety net clinics to see more clients. There are economic consequences to communities. People without health insurance have high medical bills which, when they go unpaid, have become the #1 cause of personal bankruptcy. This, in turn, will have an economic impact on businesses. Rick Wopat asked if the OPHR can measure these consequences? Bruce Goldberg responded that his office would research that. Dr. Goldberg commented on regional variations from the survey. The big issue is age. Areas with an older population will show more insured (lower rates of uninsurance) since Medicare covers nearly all who are 65 or older. Kelley Kaiser asked Dr. Goldberg if his office would show a comparison of the 8 demographic areas by county. Dr. Goldberg indicated a comparison of the 8 demographic areas could not be displayed by county because the numbers surveyed are simply too small in some counties. However, Oregon Health Plan (OHP)	Information item

OHPR Administrator's Report	enrollment can be reported by county, broken out by Children's Health Insurance Program (CHIP), OHP Plus and OHP Standard. Some counties have 17-18% enrollment, others 7-8%. ***Oregon Health Policy Commission*** Bruce Goldberg explained that it is the role of Medicaid Advisory Committee (MAC) is to provide advice on Medicaid-related issues to the Office of Medical Assistance Programs and to provide advice and direction on Medicaid policy to the Health Policy Commission. For example, the MAC provided their comments on the Health Policy Commission's report last fall. Partly as a result of that input, three workgroups are being convened to study the following issues: • Oregon Health Plan Administrative Efficiencies • Oregon Health Plan Cost Drivers • Long Term Care Dr. Goldberg announced that Gretchen Morley has been hired to replace Mike Bonetto as Director of the Health Policy Commission. Gretchen has a strong background in health policy in her prior work experience with the federal Office of Management and Budget and the Robert Wood Johnson Foundation. The Health Policy Commission has sponsored 12 legislative bills this session. Three initiatives will be finalized: • Transparency of information initiative • Healthy Oregon initiative • Delivery system redesign to promote community innovation	Information item

<table>
<tr>
<td>OHPR Administrator's Report</td>
<td>Medicaid Advisory Committee Membership
Committee members serve two terms at the pleasure of the Governor. OHPR is currently in the process of contacting and soliciting interest of new members to replace current members who have completed two terms on the MAC. Interest forms will be submitted to the Governor for appointment to the Committee. Dr. Goldberg and Bob DiPrete will work towards a smooth transition from current membership to new membership.

Kelley Kaiser requested that a list of new Medicaid Advisory Committee nominees be forwarded to the Committee.

Michael Garland asked that the Oregon Health Decisions survey on health values be included on the agenda for the next Committee meeting.

Bruce Goldberg indicated that one of the roles of the Committee would focus on how to restructure Medicaid programs and to more effectively meet policy objectives. He wants to solicit ideas from the Committee on what can to be done to create an improved Medicaid program for the improved health of the people of Oregon.

Dr. Goldberg will bring to the next Committee meeting:
• County-by county OHP enrollment breakdown
• Updates on the Health Policy Commission legislative bills
• Nominees for the Medicaid Advisory Committee
• Oregon Health Decisions survey
• Ideas to consider re future Medicaid policy changes</td>
<td>Information item

Bruce Goldberg will bring requested documents to the next Committee meeting.</td>
</tr>
</table>

DHS/OMAP Report	Barney Speight, Administrator, Office of Medical Assistance Programs (OMAP) explained the 2005-07 Governor's Recommended Budget (GRB) and its impact on the Oregon Health Plan. The GRB proposes to fund 387,000 OHP enrollees over the biennium with approximately $740 million General Fund. DHS requests that were not included in the in the Governor's Recommended Budget: • 3,100 eligibles no longer covered in Seniors and People with Disabilities • discontinuation of adult dental services and exams • discontinuation of adult vision exams The Joint Ways and Means Committee will hear the Office of Medical Assistance Programs' (OMAP) budget presentation February 14-17. ***OHP Standard Glidepath:*** When the OHP Standard Program closed to new enrollment, OMAP was directed to lower enrollment to 24,525 by June 30, 2005. The program is now being supported by provider tax revenue and other revenue, and not with General Funds. DHS staff have been monitoring the enrollment since August 1, 2004, when the membership was 53,354. As of January 1, 2005, enrollment has dropped to 33,136 and appears to be headed for the June 30 target level. ***OHP Standard Premiums:*** The proposal to eliminate premiums for clients with incomes falling below 10% of federal poverty was presented to the Legislative Emergency Board in November 2004.	Information item

DHS/OMAP Report	Decision was to defer action and refer the proposal to the January 2005 Legislative Emergency Board. The report was accepted by the Legislative Emergency Board, which then made the decision that premiums not be eliminated. 44% of enrollees in the OHP Standard Program have incomes that fall below 10% of federal poverty. Barney Speight reminded the Committee that premium sponsorship is an organized, privately subsidized program in the counties. Currently, 2,500 to 3,000 persons have retained coverage through premium sponsorships. Kelley Kaiser asked Mr. Speight for suggestions on what the Committee can do to address the premium issue. Barney Speight responded he didn't have any suggestions at this time. There is a strong feeling within the Legislature that some personal responsibility needs to accompany eligibility in programs. Mr. Speight would like the Committee to have discussions around alternatives. Rick Wopat commented that a task force on Safety Net displayed a graph that showed people with incomes below 10% of federal poverty are impacted disproportionately by premiums. People who fall in this income category do not have personal resources and eventually will go to the safety net clinics for health care. People will still receive services, but often with a cost shift to safety net clinics and hospitals. Is it possible to change the premium structure? Barney Speight responded that it might be possible but only with legislative and CMS approval.	Information item

DHS/OMAP Report	Rick Wopat asked if it was possible for the Committee to see data on clients who were not re-certified after 6 months and so leave the OHP. Barney Speight responded he will bring the available information on the topic to the Committee, including the advance notices that are mailed to clients reminding them that it is time to recertify for the OHP. ***Medicare, Part D (drugs):*** Seniors will have to enroll in the new Medicare Part D program between November 13, 2005 and December 31, 2005 to be eligible for the prescription drug program that starts January 2006. The start date for enrollment will probably be moved back to October 2005. Medicare Part D replaces prescription drug coverage for approximately 50,000 dual eligibles in Oregon. The state is actively working with senior groups and Area Agencies on Aging (AAAs) to enroll clients in the new program. Kelley Kaiser applauded OMAP for taking a proactive approach to make this work and would like periodic updates. Barney Speight agreed to provide updates and confirmed that Seniors and People with Disabilities (SPD) staff have actively been working with providers to make this a smooth transition for clients. Rick Wopat inquired what the bottom line effect will be on the state for health care spending with Medicare Part D. Barney Speight responded he would provide summary of future implications to the Committee. There are no savings in the short term. ***MMIS:*** The Medicaid Management Information Systems (MMIS) is a computer system required by the federal government for states. It	Information item

DHS/OMAP Report	is both a claims payment and information system. Oregon's MMIS is outdated, about 30 years old, and programmed in Cobol which is not used anymore. DHS is in the process of replacing the system, due to be operational by the fall of 2007. The short-term issue is how to keep a frail system running until it can be replaced. DHS staff need to be selective about what new projects are started that put an increased burden on this system. Barney Speight will provide the Committee members with a copy of the first year evaluation of the Disease Management Program (asthma, diabetes and congestive heart failure). Oregon has estimated a savings of $6 million. Currently 6,000-7,000 enrollees are enrolled in the disease management program. DHS will be moving to HIPAA Transaction Code Sets – the standard format for transmitting claims electronically and provider payments. Providers are encouraged to submit claims electronically. A clean claim can be processed in 7 days if submitted electronically. The same claim submitted on paper will take about 60 days to process. DHS will be providing more outreach to providers in this area. Rosemari Davis suggested that OMAP work through the professional associations to get the word out to providers about these transaction code sets. Hospitals already submit claims electronically. There is a need to survey how providers are moving toward HIPAA compliance. Barney Speight indicated there will be a national debate on Medicaid policy in the coming year. The role of Medicaid in a federal/state partnership over the next decade will be a big issue in Congress.	Information item

DHS/OMAP Report	Elizabeth Byers inquired if studies are being conducted on the health status of OHP enrollees. Barney Speight responded there is an External Quality Review Organization (EQRO) that studies health status, and he will provide data to the Committee on the health status of all Medicaid recipients and the health status of the mandatory and optional OHP populations. Kelley Kaiser summarized what Barney Speight would bring back to the Committee: 1. Data on populations that drop off OHP Standard program by income level. 2. Process for notifying clients on re-determination for eligibility in the OHP, and information that is provided to those who are dropped from OHP Standard. 3. Update on Medicare Part D progress and impact on clients. 4. Invite staff from Seniors and People with Disabilities (SPD) to share prospective on Medicare Part D. 5. Provide copy of Disease Management Program summary. 6. Report from External Quality Review Organization on health status studies. 7. Provide Executive Summary from the 2003 CAPS Survey for adults and children – Medicaid membership satisfaction survey. Michael Garland suggested the Committee also focus on creative alternatives for those with very low incomes to demonstrate personal responsibility, besides cash payments. He emphasized that this is an important issue for the MAC to work on.	Barney Speight will bring requested reports to Committee at next meeting.

Upcoming Legislative Session	Bruce Goldberg commented that key legislation probably will not focus on issues directly relating to the OHP. He doesn't believe there will be much significant legislative action on the OHP programs this legislative session. However, there is legislative interest in restoring adult dental and there will probably be discussions around fee-for-service prescription drugs and the Medicare Modernization Act-Medicare Part D program. The 2005 legislative session will be more a positioning session rather than one of taking action. Legislators will be asking questions about what programs should look like in the future. DHS will have a better picture as we move into the 2007 legislative session of what changes to the OHP programs will best serve Oregon.	Information item
Other	The next Committee meeting will be held on Thursday, February 24, 2005, from 9:30 am to 12:00 noon, in Room 137C and D, Human Services Building, 500 Summer Street, N.E., in Salem. Meeting adjourned.	

Medicaid Advisory Committee
December 1, 2005

Present: Elizabeth Byers, Michael Garland, Kelley Kaiser, Tina Kotek, Yves Lefranc, MD, Jim Russell, Dick Stenson, Rick Wopat, MD

Absent: Bruce Bliatout, Donna Crawford, Carole Romm, Carmen Urbina, Michael Volpe

OHPR: Bob DiPrete, Jeanene Smith

OMAP: Lynn Read, Mary Reitan

Opening Remarks

Tina Kotek commented she will be meeting with Erinn Kelley-Siel, Governor's Office, to talk about the Governor's proposals around insuring children. She reported that the Governor's Office intends to engage the Medicaid Advisory Committee (MAC) around a proposal to insure more children under the Oregon Health Plan (OHP). She also noted that two other efforts are currently underway to insure more children:

- A ballot measure to increase the tobacco tax by 60 cents to insure all children in Oregon and also to buy back some OHP Standard slots

- Oregon Nurses' Association proposal that will be aligned with one of the interim committees on children's health

Dr. Lefranc inquired if prenatal care will be paid for CAWEM clients.

Lynn Read, Office of Medical Assistance Programs (OMAP), responded that there had been some discussions about the ability to provide prenatal care to non-citizen women who are pregnant and those discussions are ongoing.

Introductions

Introductions were made by Committee members.

Approval of the Minutes
Tina Kotek welcomed a motion to approve the minutes from the last Committee meeting on November 3rd and asked for any comments. The minutes were approved as written.

2006 Medicaid Advisory Committee Meetings

Bob DiPrete asked Committee members to identify a standing day of the month for Committee meetings and encouraged them to be as flexible as they could regarding other meetings and respond to Mary Reitan when she contacts them. Bob noted that it will be increasingly important to have as complete attendance as possible over the next few months because the Committee will be moving quickly through a substantial agenda including expanded coverage for children and what the Oregon Health Plan should look like in the future.

Information Management

Michael Garland explained that he met with Carole Romm, Carmen Urbina to discuss what kinds of data would make the world more visible to them as the Committee tries to shape advice about the Medicaid program. He explained the chart handed to members and that the theory behind it is essentially the approach of value-based thinking to get some clarity about what it is that is important and then see what data, facts and probabilities cluster around those values that are important. The Committee would then decide what facts should be changed or what probabilities should be altered.

Number of persons covered by a proposal – It is important for the Committee to see the current picture, the constant, ongoing, trended Oregon stats about the number of people who are covered, who are uninsured, who has third party coverage and how does that third party coverage distribute itself, so that they could take note of proposed changes that are intended to either cover more people or cover fewer people. They would also be able to watch the trends occurring since the OHP was implemented.

Top 15 diagnoses of the population groups by frequency and cost –The Committee would explore those groups of people with health problems who the state is most involved assisting. Michael Garland believes this should be enlarged to groups of diagnoses or groups of health problems.

Dr. Lefranc asked if there is a way to collect that data. Michael Garland responded some of that is available already.

Effects of proposals on population groups – Which of the income groups, age groups, geographical distribution, or ethnic groups in Medicaid does this most impact?

Effects of proposed policies on health status of population groups – This would be looking at disease categories and what should be changed.

Rick Wopat asked Michael Garland if population could be defined: does it mean the population that is covered or the population as a whole?

Michael Garland explained he meant populations that could be broken down into groups: age categories, persons with chronic diseases. The Committee would want to see data to advise on what is rational relative to goals they want to pursue.

Relative efficiency of Medicaid vs. private insurance in constant dollars, i.e. comparison of OHP capitation rates to private insurance. It is important for the Committee to have a really clear sense of the efficiency with which Medicaid carries out its job of paying for health care provided to a specific population and that the comparative would be how efficient are the various private insurance schemes for this.

Federal dollars not attracted to Oregon as a result of proposed changes – Michael Garland would like the Committee to really keep track of the amount of federal dollars that are actually available given that under current regulations Oregon may not be going to the maximum of allowable federal match for Medicaid programs.

Michael Garland said the above categories would show the current picture, trends over time and have something that looks into the specifics of a given proposal.

Dr. Lefranc asked if data would be available for a comparison of the relative efficiency of approaches to caring for the patients or the way to select what is paid and what is not.

Michael Garland responded that benefits covered are paid for at a certain per member per month price. The problem is the benefit packages are rarely strictly comparable. This makes it difficult to address questions such as: can we do what we hope to do through the private market better than through Medicaid? Is there a better policy option that we should be recommending? Are Medicaid's administrative costs higher than the administrative costs of private insurance for roughly similar packages?

Elizabeth Byers indicated that she would like to see projected trends added as a category. She added coverage is one component but actual access is another.

Tina Kotek added it would be interesting to have data on health status and impacts on future costs, so that the Committee might quantify the cost implications of various options. The Committee could then say this is the long-term cost or the long-term savings of doing it this way.

Dr. Lefranc expressed interest in the most common or most costly services. Lower back pain for example is very challenging. Over time, lower back pain costs billions of dollars in days lost in the work force. He suggested reviewing the 15 most expensive ICD9s, which in all probability would include chronic conditions such as diabetes, hypertension, as opposed to reviewing just the diagnoses associated with the frequent visits.

Michael Garland said one of the things to look at for efficiency would be the in-clinic experience of clinicians trying to get things done within the Medicaid framework compared to getting them done in the private insurance frame.

Dr. Lefranc asked if resource limitations should be acknowledged and taken into account.

Elizabeth Byers mentioned in the 2003 legislative session, there was legislation for special case management for four conditions: asthma, heart disease, diabetes, depression. Information about that process would really feed into reviewing the most costly diagnoses.

Michael Garland said as this sort of data is generated and reported by DHS, the Committee needs to be pulling it together and putting it into a format it can use to develop policy recommendations.

Rick Wopat said it would be interesting to have some of this information on our population as a whole in terms of comparisons – the state population contrasted with the uninsured population for example - so the Committee had some sense of where there are significant differences by sub-population.

Dr. Lefranc suggested the Committee have data on the comparison of how much was paid for treating children with common colds versus treating diabetics with congestive heart failure. He mentioned an article, published in the American College of Obstetrics and Gynecology, regarding paying for prenatal care for undocumented women in California. For every dollar they thought they had saved by not providing prenatal care for undocumented women, the state ended up spending $9 in complications. The Committee should consider tracking the consequences of not providing care as well as the costs of services provided.

Jim Russell asked Michael Garland how he would move ahead.

Michael Garland said he would meet with Lynn Read and Bob DiPrete to find out how much data is already there and how to fit the available data then into the categories and also find out what isn't there.

OMAP Update

Tina Kotek asked Lynn Read, when presenting her update, to focus on a reduction already proposed as an example to see how this plays out on a very specific case.

Lynn Read said she believes there are opportunities for the Committee in terms of data, reports, information that the Office of Medical Assistance Programs (OMAP) and the Office of Oregon Health Policy and Research (OHPR) has. There are other data requests that would be a real challenge in terms of what could be done. The Office of Oregon Health Policy and Research, commercial insurance and the Family Health Insurance Assistance Programs (who serve a similar population) could also be involved. Lynn mentioned from the discussion at last month's Committee meeting, she took back to the department several assignments and provided the Committee with the handouts. One of the handouts was an attempt to get at some of the information they are looking for as it related to the hospital-day limit.

Tina Kotek asked Committee members if it would make sense to have Michael Garland, Carole Romm and Carmen Urbina work with OMAP on the next phase of data sharing. Lynn Read suggested it be a broader group, the Department of Human Services (DHS), including the financial unit and the caseload forecasting unit, and the Office for Oregon Health Policy and Research.

Lynn Read then explained the document prepared on the proposed hospital-day limit in terms of who are the clients impacted to Committee members. This reduction item was based on reviewing claims from July 2002 through June 2003.

- Of 100,000 Oregon Health Plan (OHP) fee-for-service clients, 157 clients would not have hospital stays covered if this policy were implemented.

- Clients in the Aid to the Blind/Aid to the Disabled (AB/AD) category would be disproportionately impacted by the hospital day limit. 21% of the OHP population was in that eligibility category in 2003, but almost 90% (141 clients) of the clients that would have been affected were in the AB/AD category.

- The hospital-day limit would disproportionately impact OHP clients by age, age 50-59, where about 14% of the OHP population was in that age group. 29% (46 clients) who would have been affected were in this age category.

- There would also be some disproportionate impacts by racial and ethnic categories although it was felt that some of that may be driven by other factors such as age, eligibility, etc. and may or may not be directly related to race and ethnicity.

- Location could also disproportionately impact clients but wasn't taken into consideration as some of the DRG hospitals are in larger urban areas.

The data was examined not only by clients but how many claims were there. 157 clients – 337 claims would indicate on average these individuals were having two stays that occurred after the 18 days had been used up.

The dollar amount was identified in terms of how much OMAP pays for those claims that wouldn't be paid under this new proposal.

A range showed the variation between small dollar claims and the highest cost claims that wouldn't have been paid by eligibility category. It shows the variation.

Hospital day limit data extracted by:

- Eligibility category
- Age group – starting with age 19 through age 79
- Race/ethnicity

Dual eligibles (both Medicare and Medicaid) comprise about 40% of the AB/AD eligibility group. This group is growing. About 60,000 clients are in the AB/AD category. The senior population includes about 30,000 clients, the majority of which would have Medicare coverage.

Dr. Lefranc asked whether it is known why African/Americans, who are only 3.8% of the population, have 6.8% of the claims over 18 hospital days and Native Americans, at 1.9% of the population, have 5.9% of the claims over 18 hospital days. He wondered why they stay so long at the hospital. Were they not receiving the same quality of care? This disparity may reflect the national trend that minorities are getting less timely care, or these populations may have more complications, or something else may be happening.

Lynn Read indicated that the statistics certainly raises more questions than they answer. The database used for this sampling was small but if we look at the population as a whole, then we could move away from the small numbers issue and see if the patterns hold up.

Michael Garland said this begins to show the picture of the categories the Committee is really trying to understand as part of its advisory responsibilities.

Michael also expressed concern about policies that deliberately reinstitute cost shifting. The hospital will still have to cover the client's care after the 18 days.

Lynn Read indicated the Committee needs to remember the proposed policy doesn't end payment at 18 days. If someone is admitted to the hospital prior to using their 18 days, the entire stay would be paid even if it was 200 days. If a client has used their 18 days and then needs to be readmitted to a hospital, that stay would not be paid. That would shift costs.

Dr. Lefranc added during the last five years he has only one patient who stayed more than 18 days. It is quite unusual to have patients stay more than 18 hospital days. But many times, patients stay 3 or 4 days extra just to find placement in an appropriate care setting. If the patient has no money, no insurance, no home, then it takes forever to find a place that will take them. That may be something for the Committee to look into.

Dr. Wopat commented the data is interesting information but the state needs to make public policy on good sound judgments as opposed to personal interest issues. He believes the Committee has to be careful, in a resource limited situation, that they not be too focused on takeaways from these people who have coverage, as they might not have any coverage if they didn't have the OHP. Each proposed program change should trigger a series of questions, such as: What happens if we don't do this? What will be cut? Who will lose? Are people going to be taken off altogether? Are we going to reduce benefits for a larger population? The Committee will have to keep the big picture in mind when they are talking about the personal impacts or population impacts of cuts.

Michael Garland added, wherever possible, the Committee needs to put trade-off perspectives into the picture.

Elizabeth Byers would like to see geographic location added as a category.

Lynn Read explained the two diagnoses that will be most impacted by the proposal to limit hospital days:

- Diseases and disorders of the Respiratory System (respiratory infections)
- Diseases and disorders of the Circulatory System (heart failure)

About 26% of OHP clients fall in those two categories, and about 31% of the claims fall into those categories.

Dr. Wopat said these are people who have underlying respiratory diseases (asthma, emphysema, COPD) that are not infectious diseases.

Dr. Lefranc indicated people do not tolerate shortness of breath, and that this symptom is one of the fastest ways to send someone to the hospital, and get them admitted. Chronic pulmonary disease and chronic heart failure are the main two reasons for people to have shortness of breath, and those patients are admitted to the hospital immediately which may drive the fact the admissions are frequent and hospital stays are long. Many nursing homes will not take these patients, and many families feel uncomfortable taking patients like that. Obtaining oxygen sometimes is a little more challenging because sometimes people don't qualify for the requirements for oxygen but they are short of breath, so they return back in the emergency room.

Lynn Read noted as a tie-in with the Committee's broader information request for case management that the disease management program came out of the 2003 legislative session and provides service for the OHP fee-for-service population. It is not available to the Medicare dual eligible population. The program addresses asthma, diabetes, and heart failure and is currently being expanded to include chronic obstructive pulmonary disease (COPD) and coronary artery disease (CAD). The program will also include a nurse advice hotline.

Tina Kotek commented that it is becoming more clear what kinds of data the Committee is looking for is there. It will be just a matter of pulling it together in the most efficient way possible.

Lynn Read updated the Committee on the waiver request DHS submitted to CMS related to a change in premiums for OHP Standard clients. The federal government has raised issues about the fact that Oregon's uses that premium revenue as the state's share for Medicaid services and draws down federal match. If Oregon has to pay the federal government their share of premium revenue up front, the OHP would serve 641 fewer OHP Standard clients.

DHS has submitted three different waiver requests.

- Benefit changes
- Premium changes
- Flexibility in terms of how some of the FHIAP maintenance of effort money might be spent.

Lynn Read indicated the most recent interaction with CMS this week was that they were likely to bundle the premium request together with the FHIAP

maintenance of effort request and believes CMS would have a decision to Oregon by the end of this month.

Action Item:

Lynn will provide an update at the next Committee meeting.

Office of Oregon Health Policy and Research (OHPR) Update

Jeanene Smith, Interim Administrator, OHPR, explained her office will be working closely with the Medicaid Advisory Committee and Health Policy Commission in terms of the same endeavors of trying to make the OHP system work a little bit better. OHPR will be involved working with OMAP in terms of this data. Some of the data is feasible, but some will be very difficult to get.

Dr. Wopat asked Jeanene Smith to what degree OHPR had been involved with the Governor’s children’s and families’ health agenda.

Dr. Smith said OHPR’s role is to help advise the Governor and the legislature about potential health policy approaches. They are working closely with the Governor’s office and legislators. OHPR is involved with exploring how to cover more people, talking to advocates regularly and working with the Oregon Health Action Campaign.

Dr. Wopat said the Governor made some proposals related to children’s health care that were pretty well fully proposed without discussion at all with this Committee. He suggested that if the Committee is going to advise on a coherent health policy in this state, there needs to be communication between the Governor’s office, OHPR and the advisory committee in relation to those issues. The Committee would need to know what’s going on and have some input into that before it becomes a full-fledged plan and then be caught in a position of trying to look at it and decide how to work with it at that point in time.

Jeanene Smith indicated the Governor’s office plans to involve the Medicaid Advisory Committee in any decisions or suggestions about Medicaid programs.

MAC and OHP Redesign

Bob DiPrete handed out a series of timelines to Committee members that lay out what has to happen between January 2005 and October 2007 to decide on changes the Committee would want to make on the OHP, work those through the legislative process and the Governor's budget building process. All decisions made by the various parts of state government and advisory groups must coincide so that the waiver application can be submitted to CMS to get their permission in order to make the changes to the Oregon Health Plan (OHP) and still receive federal match.

The handout shows very general timelines in what has to happen with the waiver, the legislature and the budget building and fiscal year timelines.

The Committee will need to develop a timeline that can be set along side these timelines, which identifies the points at which the Committee is going to want to weigh in with a recommendation or other involvement in the process. It will then be part of the packet for the January meeting. The most important dates on these timelines have to do with the legislative process and the Governor's budget building timelines. The deadline for DHS to submit legislative concepts is mid April. The Committee will have three to four meetings to discuss issues relating any legislative concepts that might be needed to support changes in the OHP.

Action item:
A draft of those timelines will be developed and sent out to Committee members prior to the January meeting for comment.

Other deadlines the Committee should keep in mind have to do with the Governor's budget building process which begins in January and is all pulled together in early fall. The deadline for the Governor having all those pieces pulled together for his proposed budget is late October, but recommendations should be made well before then.

Tina Kotek summarized – the budget is developed around the current service level and then agencies are asked to submit their 10% and 10% reduction proposals. There are also policy packages and legislative concepts that

support that policy which are overlaid on that and come into the budget process later on.

Lynn Read added the policy packages and legislative concepts are developed in April but ultimately do not show up in a document until the Agency Request Budget is submitted on September 1st.

Dr. Wopat asked about the status of the Medicaid Commission.

Lynn Read responded the Commission was charged with coming up with some short-term recommendations for savings of $10 billion by the September 1st deadline. Some of those are at play right now in the federal budget reconciliation process. Their longer-term charge was to come up with a more comprehensive Medicaid reform by December 2006. They have just had the first meeting to start to look at the longer-term issues such as cost sharing implications or more flexibility for states in terms of benefit design. There is a federal protection under current law around categorical groups of clients and mandatory services that are required to be covered under a Medicaid program.

Michael Garland asked if the National Governor's Association report will dramatically influence this Medicaid Commission.

Lynn Read said there is a lot of correlation between the short-term recommendations of the Medicaid Reform Commission and the National Governor's Association. Lynn believes there will be significant similarity through that process.

Jim Russell asked if the 2007 legislative session would be necessary for any restructuring of the Oregon Health Plan (OHP).

Bob DiPrete answered that Oregon has to submit the waiver extension request before the 2007 legislative session. The issues for substantive changes to OHP will be a part of the 2007 legislative deliberative process, and then Oregon will submit a waiver amendment request following the 2007 legislative session to apply to CMS for the changes Oregon needs to make the OHP sustainable and effective.

Bob DiPrete added the recommendations for changes to the OHP are going to be part of the legislative concept process and the Governor's budget

building process. It will be important that issues to be proposed for legislative action or the Governor's budget building be put on the table soon.

Tina Kotek asked Bob DiPrete if he had suggestions on how the Committee might accomplish this in the next three meetings.

Bob DiPrete suggested issues that the Committee should focus their attention on:

- Benefits provided under the OHP – who would be eligible for those benefits and how to ensure the people get the benefits they're supposed to get once they are determined eligible for them?

- Eligibility – People, who used to be on OHP Standard, no longer have coverage and are now uninsured. Many of those people have chronic conditions that haven't gone away simply because they lost their eligibility.

- Access - Which populations are most in need of improved access to health and what kind of access is most effective for them?

- Delivery system – Until we know which benefits are going to be provided and to which populations, it's hard to have a really meaningful discussion about how the delivery system should be constructed to do that.

Bob also noted that the Committee will need to have the best information possible about what's happening in the development of legislative concepts coming out of DHS and elsewhere having to do with Medicaid. The Committee will also need to be informed about what's going into the Governor's budget development. The Committee will have to be proactive and be thinking on its own aside from what's being developed by DHS or the Governor' staff, about what they think is important to make the Medicaid program more effective. And, the Committee will need to talk about the resources available and what the trade-offs are within those resource limitations.

The Committee should also be focusing attention to cost efficiencies, how the Medicaid program is going after cost efficiencies and what the promise

and probability of pay-off is. An example would be focusing on which benefits are most important to cover, and why.

Dr. Lefranc asked what the consequences of the decisions the Committee makes are, especially cost shifting. If more money is put into preventive services, saving lives for a little money, will some other chronic disease or more challenging population be cut off? These people will still go the emergency room, be admitted and that cost will go somewhere. What are consequences of that cost shift?

Tina Kotek added she would like to keep FHIAP in the discussion. Tina Kotek and Carole Romm will be working with Bob DiPrete to have focused meetings during January through March so they can start to take positions at the meetings.

Benefits and Delivery System

Dr. Wopat provided a power point presentation to Committee members of his proposal, and asked for feedback about how his proposal might work, what doesn't work with it and how he might improve the proposal. His presentation will review the objectives and realities of the OHP and the concepts that brought the program to where it is, and then he will discuss a proposal for a more limited benefit for the OHP Standard population.

Dr. Wopat opened his presentation about his biases because he believes it is important for the Committee to understand where he's coming from. Although he believes that it is our responsibility as an affluent society to provide adequate, affordable, basic health care to all, his proposal doesn't do that. It provides a different approach to providing health care but does not provide adequate, affordable basic health care for all. He also believes that health care is rationed in the present delivery system, based on income and social status. Current health care spending is adequate but poorly focused and provides poor value. In order to get to universal coverage the state may need to make an increased investment for a period of time. The state will never achieve the savings of efficiencies without universal coverage. As long as there is a group of people with no health coverage, costs will continue to be shifted, which will drive up the health care costs for everybody.

The primary objective of the OHP is to promote health, not to promote health care. The strategy of the OHP is to increase the number of Oregonians with access to basic health care by focusing spending on more effective services and using funds wisely. That achieves the state's ability to ration services and not people. Dr. Wopat's proposal is a strategy for dealing with the current limited resource situation.

Currently, the state has reduced the number of Oregonians who have access to care by creating administrative barriers to individuals. By closing OHP Standard enrollment, the number of insured has been reduced by attrition by over 100,000 to 28,000 clients. The program would have been further reduced if people hadn't stepped in to help with some of the administrative barriers such as premiums. He believes the Committee should explore alternative approaches if we are to reduce the uninsured in Oregon and increase the number of covered individuals under OHP Standard. Potential solutions:

1. Raise more money - Dr. Wopat applauds Rep. Dalto and others for their efforts even though he doesn't like targeted taxes.

2. Eliminate OHP Standard altogether - OHP Standard currently is less than 1% of the population. The state has created a very complex system of funding and distribution without really covering a significant amount of people. We need to look at a different way of doing it.

3. Reduce the allowable income level to a smaller percentage of federal poverty level, in order to qualify for OHP Standard – This would probably be the only option if the state doesn't raise more money or eliminate a program. It continues to ration people based on income levels.

4. Create a more focused benefit package for OHP Standard to increase the number of individuals who are covered for that benefit package.

   This is the proposal Dr. Wopat is presenting, and he believes the time is an opportune to look at how the process might be changed because DHS will be reapplying for the OHP waiver. The increasing number of uninsured and limited state funds makes it imperative that we find

another approach if we want to stay within the principles of the OHP, of how to focus benefits and honor the original principles.

- A benefit package would be created focusing on the areas of highest benefit and return. It would require changes in the current prioritized list structure.

- The list would have two lines, one for OHP Plus and one for OHP Standard. The current list is a methodology that the Health Services Commission came up with. It is not the only way to prioritize health services and Dr. Wopat believes we do have the flexibility to change it within the law.

- Parity of mental, dental and physical health related services. Health and mental health would not be separate.

- The federal poverty level for qualifying adults would be left at 100%.
- Emphasis placed on prevention. Proven, effective preventive services would be covered.
- Reproductive services, including preconception counseling and contraception would be covered.
- Screening for certain chronic health conditions where management improves health and controls costs. New lines for the prioritized list would need to be created.
- A basic prevention package of services, proven to be effective, be identified by the Health Services Commission (HSC) with services including immunizations, reproductive services and others that are proven to be effective.
- A limited diagnostic package would be created. Screening for a limited number of conditions where the chronic disease model of care improve outcomes.

New lines might need to be created for disease management of certain conditions. The ranking would be re-evaluated, and there would be different cut-off lines depending on the amount of funding available. This would be necessary because of the federal government's inability allow flexibility to move the line for OHP Plus.

The proposal would include a benefit package where people would qualify for broader coverage based on their conditions. A healthy young person would be eligible for all preventive services and the benefit would stop at that point. The healthy person would not be covered for routine evaluation of a cold or sore throat. If the person had heart disease, they would have screening for hypertension and hyperlipemia, and would qualify for a broader list of services defined by the HSC. Other diseases qualifying for the broader list of services include: diabetes, chronic severe depression, congestive heart failure, schizophrenia, asthma and chronic pulmonary disease. These are conditions in which it is clear that if failure to treat will lead to higher cost in the long run and probably a significant amount of cost shifting in the system, especially in the emergency rooms and in the hospitals.

By providing tobacco cessation to a person at age 20, COPD, asthma and heart disease could be greatly reduced at age 50. Currently, the system provides care for the complications but doesn't provide the preventive care up front.

Malignancies with the potential of cure: It makes no sense to do mammograms or pap smears as preventive services if we are not going treat the preventable disease.

Some conditions that wouldn't be covered
- Osteoarthritis –
- Dysthymic disorder – mild depression
- Chronic headaches
- Fibromyalgia

A methodology would need to be developed along with financial modeling. The Committee would need to solicit input from the stakeholders (health plans, hospitals), and stakeholders would need to be convinced that it makes more sense to provide prevention than it does to provide emergency room care for ankle sprains. Emergency room (ER) services for a person with diabetes would be covered under this benefit, but it could possibly be prevented by providing the patient with insulin, medications, and education before he has to come to the ER. By expanding prevention services to a wider population,

hopefully would reduce the amount of uncompensated cost-shifted care.

This proposal may need to start as a demonstration project. The variation across the state in the ability of systems or health plans to provide a benefit package is very significant. Many areas of the state may not be able to implement this program. If the program is going to be implemented, it will have to be done within very strict guidelines and will need to be included in the new proposal waiver.

Dr. Wopat believes this is an opportunity, and there are organizations that could do this in parts of our state. We will never know what the potential savings are until we do it.

Dr. Wopat closed with two quotations: "Cure sometimes, relieve often and care always". "The best way to predict the future is to invent it."

Dr. Lefranc asked if obesity and nutrition would be part of the proposal. 60% of Americans are obese and 25-30% of children are obese. Child obesity is a big challenge for a physician's practice. School vending machines send a poor message to children. The third concern is the emergency room (ER). Physicians have no control of who goes to the ER.

Dr. Wopat commented that obesity is something the state struggles with what is proven and effective treatment. Childhood obesity and obesity in general are becoming more of an issue that is being focused on.

The emergency department is a delivery systems issue. Dr. Wopat said in his hospital if patients come in and don't meet prudent layperson standards for an acute condition, they will not be seen or receive pain medication. This practice has been found to be somewhat effective. There is no perfect system. He believes changes to the payment system and the delivery system are a way to prevent unnecessary ER visits between physicians, emergency departments and hospitals.

Michael Garland expressed concern about patients who come to the ER with frank trauma (broken bone, deep cut) that has to be treated

and asked why wouldn't that be included in this basic coverage. It's not a misuse of the emergency room, and it's an appropriate protection for members of our community who are in auto accidents, fall off bikes, break a leg in athletics.

Dr. Wopat responded as long as there is cost shifting in the system of any kind, he would rather see cost shifting of those conditions. They are not necessarily clearly avoidable. Failing to give a diabetic insulin is not an accident. Not having a COPD getting their medication is not an accident. If there is a limited amount of money, and you want to spread it over more people, it would be better to focus on things where failure to treat would lead to higher costs later. The laceration will be sutured, the broken leg will be taken care of. If a diabetic shows up and says he needs insulin, that won't necessarily happen.

Most hospitals in the state are running at about a 40% reduction of the charges they're paid. If, by reducing the number of avoidable emergency room visits and hospitalizations for chronic diseases and by avoiding avoidable pregnancies that people didn't want to have and low birth-weight babies, that non-compensated care could be reduced by 5%. It would pay for this program.

Elizabeth Byers would like to see the following included in Dr. Wopat's proposal:

- Employer contributions, especially for the larger employers like Wal-Mart.
- Drug and alcohol treatment
- Preventive dental services. Dental health is the category most impacted by prevention.

Dr. Wopat said dental would be included. Drug and alcohol treatment would also be included but there would be a trade-off. Employer contributions would require a legislative mandate and be referral to the people.

Dr. Lefranc asked if the name of OHP should be changed to OHP Prevention. People would then know they are getting the preventive service and wouldn't ask for services that are not covered. Dr. Wopat agreed.

Dick Stenson believes this proposal deserves full consideration at a time when Oregon needs to do something different and better. He believes if a significant number of those very expensive services can be prevented, then all the providers, hospitals, physicians and so forth, will benefit in the long run even though they may be taking care of a few more of the traumatic services or other things that might come along. They will find this is a better proposition.

Tina Kotek asked if this proposal is a good idea, could it be opened it up to everyone who doesn't have insurance. Could a cost analysis be done if this was expanded further? This would have cost savings across the system.

Dr. Wopat would be more than happy to explore that in a pilot region. In Linn, Benton and Lincoln counties there are clinics who see people at no charge and provide them with a short list of generic medications at no cost. Restrictions had to be placed that only people residing in those counties receive services, as people from other counties were coming in to get the services.

Kelley Kaiser said from a plan perspective, the proposal would need to be defined within the current delivery system as to the expectations and how it would be funded or it would be really difficult to get the delivery systems to administer it. She believes from a plan perspective that they would want to and the delivery systems are in place in the majority of the state to do that.

Dr. Wopat would love to see that as a demonstration project in a region but the issue would be convincing people who have to pay for services at some level. He suggested universal screening for diabetes and received the comment, what would you do with all the diabetics? That would create some pressure on the system.

Meeting adjourned.